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THE FINAL REPORT

November 25th, 1991

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Actual drawing by a survivor of sexual abuse.

TASK FORCE ON SEXUAL ABUSE OF PATIENTS

An Independent Task Force
Commissioned by
The College of Physicians
and Surgeons of Ontario

Marilou McPhedran, Chairperson
Harvey Armstrong
Rachel Edney
Pat Marshall
Roz Roach
Briar Long, Coordinator
Bonnie Homeniuk, Technical Coordinator



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...and never do harm to anyone...

...In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially free from the pleasure of love with women or with men...

- excerpts from the Hippocratic Oath

"I couldn't refuse him, just like I couldn't refuse my uncle [when I was a child]... You tell me why he's allowed to live in happiness when I hurt so much inside..."

- ***excerpts from a 20-minute message left on the Task Force line at 10:50 on a Friday night***

"

...I would like to thank you for providing a safe place for people to speak...I cannot adequately express what that has meant to me, or how grateful I remain to all of you. Thank you so very much. Whatever happens with the recommendations in the final report you have already succeeded. You have brought this issue to the surface and judging by the response of victims, it will not be submerged again. And you have touched people's lives."

- ***A letter from a survivor of physician sexual abuse who participated in a public hearing.***

"... the gender opaque formulation of philosophical arguments leads the reader to see the moral participants involved as generic, non-differentiated individuals who are interchangeable players in the sexual contact game. This encourages a view of the players as equally situated and, in principle, equally powerful in the decision-making process. This is pernicious in two ways. First, it renders relatively invisible the enormous power differential built in between any physician and patient, and second, it supports a completely mythic notion of gender equality."

- Kathryn Morgan, Ph.D., Department of Philosophy, Women's Studies Programme and The Centre for Bioethics, University of Toronto

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Marilou McPhedran



"But you're a lawyer - you didn't even cross-examine them - why do you believe them?"

"Why not believe them?"

Patients are vulnerable, trusting, they expect to be protected - and sadly, they are easy targets. When they are betrayed and used for the sexual gratification of a powerful caregiver, they do not want to accept the truth of the abuse. They do not want to feel tainted by it. It is a pattern among survivors of sexual abuse - and a normal human response - to deny the abuse, discount it, blame themselves for it, even to return to the caregiver with the hope that it won't be repeated. When survivors, who often take a long time to face the horror of what has happened to them, do choose to speak out about it, they do so with great pain, courage, and credibility.

I was honoured to chair this independent Task Force: to work with our Advisory Council and our team: Briar, Bonnie, Harvey, Pat, Rachel and Roz. I have been overwhelmed at times by the suffering caused and human potential lost due to abuse. I am blessed with friends and family who have supported me through this difficult process, especially: Arnold, Bark, Beth, Bet, Caroline, Ede, Edna, Marilyn, Nancy, Patrick, and Val. My appreciation also to Ruth, my parents, and my sons, David and Jonathan.

By commissioning this Task Force, the college of Physicians and Surgeons of Ontario has assumed a role of leadership in seeking solutions to the problem of sexual abuse of patients. As leaders, and as the "bearers of bad news," doctors should not be forced to carry the blame. Nor should all doctors be blamed for the errors of some.

But at the same time, the fact of abuse must be faced, and the medical profession must not shelter abusers. Because our Preliminary Report delivered a lot of painful truths, we expected considerable denial about our findings: "It can't be that bad...Not enough scientific research has been done...Doctors can't be made scapegoats..." We did not expect, however, the intensity of the extenuated and furious backlash from many doctors and their lawyers.

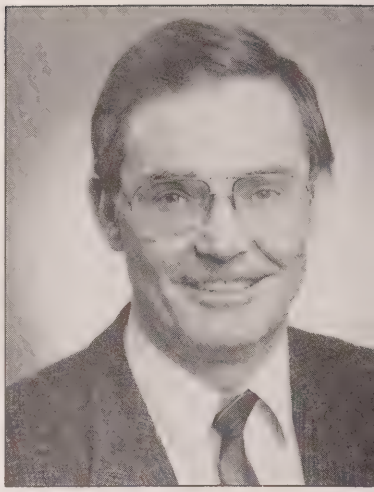
Some of our Preliminary Recommendations have already begun ripples of change. Ontario's Minister of Health, the Honourable Frances Lankin, has committed to a policy of **Zero Tolerance**, stating her goal "to enact a law that will deter sexual abuse, bring abusers to justice and treat victims with greater sensitivity and respect."

Reader, stay with us through the journey of this report. Be open to the voices in it. They are speaking urgently to us about doctors, lawyers, teachers, clergy, nurses, social workers, hospital administrators and others who have been invested with status, trust and power. If we allow ourselves to hear them, we will be able to move beyond the collective denial and resistance that have enabled abusers and allowed the suffering of patients for too long.

The first steps have finally been taken . . . let us continue the work we have begun.

Marilou McPhedran graduated from Osgoode Hall Law School in 1976 and was appointed a member of the Order of Canada in 1985. Ms. McPhedran was born and raised in Manitoba. combining a high level of volunteer commitment with her law practice and single motherhood of two young sons, Ms. McPhedran's interests lie primarily in the areas of equality and health issues. A feminist, she is active in many organizations such as the Ad Hoc Committee of Canadian Women on the Constitution which sought to amend the Meech Lake Accord to ensure the protection of equality rights in the Charter of Rights and Freedoms. As a founder, she continues to devote time and energy to Metrac, the Metro Action Committee on Violence against Women and Children and LEAF, the Women's Legal Education and Action Fund. She also does work with the City of Toronto and played an integral part in the planning and implementation of the newly-opened Gerstein Crisis Centre for discharged psychiatric patients in Toronto. More recently, Ms. McPhedran acted for the coalition of over 1000 "FRIENDS" - patients, donors, volunteers, doctors, nurses and other staff at Women's College Hospital who successfully prevented the disappearance of the hospital due to merger. Ms. McPhedran practices law in her own way, representing clients who are challenging the effects of rape, incest and sexual harassment, and works with organizations concerned about equality rights and health issues.

Dr. Harvey Armstrong



In my experience as a child psychiatrist part-time at the Hospital For Sick Children, The University of Toronto - Sioux Lookout Program, The Clarke Institute, Youthdale, Parents for Youth Ltd., and in private practice, I have seen about 1500 cases of sexual abuse. Shirley Turcotte, my first survivor, taught me much before she made To a Safer Place. A year at S.C.A.N. brought an understanding of the impact of abuse on younger children. When I canvassed the parents of out-of-control youth, 60% remembered abuse, and 12% admitted to sexual abuse. More than twenty survivors I have worked with in the past have been abused by doctors. When the Task Force began, I started to ask all the survivors I am working with, and some have shamefully admitted to one, two, or three medical abusers.

Harvey Armstrong is a child and adolescent psychiatrist who was raised in many parts of the world. He trained primarily in Toronto, and has long term interests in difficult adolescents, parenting, crisis intervention, first nations people, group therapy, sexual abuse, transcultural psychiatry, community psychiatry, dissociation, and multiple personality. Currently an Associate Professor of Psychiatry working as the Executive Director of Parents for Youth Ltd., staff psychiatrist at the Hospital For Sick Children and the Sioux Lookout Zone Hospital, he has a private practice that treats many survivors of abuse. Two psychiatric programs he has directed have been awarded American Psychiatric Association Gold Achievement Awards. Dr. Armstrong continues to work in the courts as an expert witness to try to increase the penalties for perpetrators of abuse to create a deterrent.

In my practice, I have personally witnessed illuminating recovery by patients who have been sexually abused repeatedly by persons in authority - including their doctors. As I celebrate the courage and positive spirit of these survivors, I must also acknowledge how challenged they are by the often unhelpful and sometimes unsafe environment in which they seek appropriate treatment. To put it bluntly, 23% of the incest survivors who go for help end up being abused sexually by their "helpers." On the average, survivors go to more than three therapists in their quest for care, yet only half of them get any measure of real help (Armworth, Mary Witham, "Therapy of Incest Survivors, Abuse or Support?" Child Abuse and Neglect, Vol. 13, pp. 549-562 and Frenken, Jos, Von Stolk, Bram, "Incest Victims; Inadequate Help by Professions," Child Abuse and Neglect, pp. 253-263, 1990).

I have attempted to report physician abusers in the past, but the College was not interested unless my patients were willing to expose their fragile equilibrium to the daunting process of the Discipline Committee. Those who entered the complaints process wished they hadn't, and felt brutalized in helping the College do its job of protecting the public. When the College offered me a chance to help change things, I had to accept.

It has been wonderful to see the courage of wounded women and some men who came forward to disclose their shame, anger, and sense of betrayal by their doctors and the College. In the College's desire to appear neutral, its response has been perceived as attacking, immediately deterring survivors from proceeding. It has been terrible to hear of the betrayal of trust, power, and knowledge by colleagues. If the College of Physicians and Surgeons is to protect the public, there must be massive monitored change.

Can we lead the self-governing professions into a new era of public protection and set a standard for others? If we fail, we cannot justify our existence as protectors of the public.

Dr. Rachel Edney



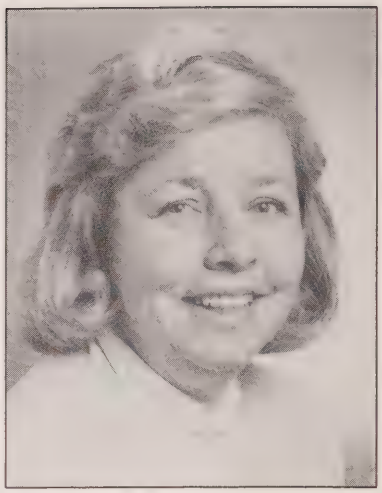
I was not asked to sit on this Task Force because of my expertise in sexual abuse, but because of my position on the College Council. I am a Family Physician in Mississauga. I chose to run for Council two years ago because I believe in self-regulation, but I felt that we, as a profession, were not always doing a very credible job. I wanted to be involved in changes which upheld the Health Disciplines Act and effectively regulated my profession "in the public interest." I also felt it important to have female doctors as representatives on Council.

The Task Force and the College have received many letters and calls following the release of the Preliminary Report. We have read and listened to them all. Many of the respondents were doctors. I can understand the feelings of concern and anger created by the report among some members of my profession. Changes have been made to this Final Report in response to the criticism; no changes have been made which compromise the underlying philosophy of Zero Tolerance, and the absolute certainty that the system must be altered drastically to help and support the victims of sexual abuse by doctors. I cannot accept that the changes which are advocated will encroach on the rights of physicians to a fair hearing. The right to due process will be preserved in any new system developed from the recommendations of the Task Force.

All doctors must understand the significance of the trust relationship they have with their patients. It is up to the doctor, NEVER the patient, to have a code of behaviour which he/she does not break. Sexual abuse of patients is unacceptable under all circumstances.

Rachel Edney is a family physician, practising with three associates in Mississauga, Ontario. She obtained her medical degree from St. Thomas Hospital Medical School, London, England in 1967, and practised medicine in Arkona, Ontario from 1970 to 1972. She also worked as a family physician in London, Ontario from 1972 to 1981. Dr. Edney has been active in the medical community and in 1976 she served as the President of the London Chapter of the College of Family Physicians of Canada, and, later as President of the Ontario Chapter. In 1988, Dr. Edney was elected to the Council of the College of Physicians and Surgeons of Ontario. She is currently the Vice-president of the College and sits on the Executive and Special Procedures Committees.

Pat Marshall



Pat Marshall has recently been appointed by the federal government to co-chair the Canadian Panel on Violence Against Women. During the course of the next year, the Panel will develop solutions to reach zero tolerance of the violence Canadian women presently experience, including the creation of a national work plan. To undertake this enormous challenge, Ms. Marshall is on leave as Executive Director of the Metro Action Committee on Public Violence Against Women and Children (METRAC), where over the past 7 years she has pioneered a number of initiatives to create a safer society for women. With the development and use of a women's safety audit kit, women's security concerns have become a priority issue on the municipal agenda. Pat's policy, education and law reform work is based on the information from the internationally recognized sexual assault sentencing data base she established and shared with judges from 22 countries. Pat is an invited member of the Society for the Reform of Criminal Law in Common Law Jurisdictions.

For a number of years, I have been committed to supporting the rights of women and children to live their lives free of violence and the threat of violence.

I believe society has been in a dissociative state when faced with the awful reality of sexual abuse by its trusted professionals. Much of my work as Executive Director of METRAC (the Metro Action Committee on Violence against Women and Children) and on this Task Force has been devoted to finding ways to help society move from that state to recognizing the terrible harms of sexual abuse and the further harms that come from disbelief of the victims. The reversal of the College of Physicians and Surgeons to the point where it acknowledged the problem and, in starting to change, created this Task Force, has encouraged me greatly. The real change, however, is yet to come.

The work of the Task Force itself was a hard journey one doesn't ever want to take. Our schedule of long hearings compounded the intensity of learning of the abuses. It helped to share the burden with very special colleagues, but each day there were tidal waves of pain from which it was difficult to recover. The spirit of the survivors who came to share their experiences "so that he might not do it again" and "so that it won't happen to other women" encouraged us to work as hard as we could to ensure that their reality is truly heard.

I dedicate my work on this Task Force to all the wonderful survivors I have met, including those women who were not able to come to tell their stories, the women whose anger and pain and courage has been the starting place of each day for me.

I have to hope that this work might make a difference for our daughters.

Roz Roach



Doctors are simply not permitted to misuse, abuse, or exploit the people who seek them out for treatment.

Most of my adult life has been invested in mothering my children and in caring for and helping people in need, both in institutions and communities.

Working on the Task Force on Sexual Abuse of Patients has been an eye-opening and heart-wrenching experience which I will not soon forget.

With a clear understanding of human behaviour, I am resolute about the profoundly devastating effects of sexual abuse by doctors and others in positions of privilege and power. Such abuse by doctors has been found to be pervasive, and includes doctors from all cultures. The survivors also span the spectrum of class and culture.

Roz is a Psychiatric Consultant, Clinical Nurse Specialist and trained Psychotherapist. She is currently working with women individually and in groups with an aim to achieve physical and emotional wellness. To this end, Roz is in the process of forming an Institute for Women's Optimal Wellness. Most recent academic pursuits have involved Psychotherapy and Transcultural Psychiatry. Roz was one of the founding members of the Charles Drew Society for Public Health Education (Montreal), and continues her active involvement in Health Education through supervising and lecturing at medical institutions.

My time with the Task Force has shown me that far too many doctors have taken advantage of the unequal distribution of power in the therapeutic relationship and are sexually abusing their patients. While there are many doctors who do not condone or practise this abusive and criminal act, there is a minority that does, thereby damaging patients physically, emotionally and spiritually.

In fact, sexual abuse by doctors is so alarmingly pervasive, my experience on the Task Force has reaffirmed my belief that those who are powerful and privileged are at least partially responsible for keeping the needy, the vulnerable, the powerless, and the helpless members of our society in their state.

Many patients, men and women, the latter being the majority, have come forward during the Task Force hearings and shared their pain and suffering resulting from the abuse by doctors. We found their testimonies were profoundly emotional and highly credible.

For many, speaking to the Task Force members was the first attempt to unlock tightly-secured secrets. From my experience as a practising therapist, it soon became evident to me that the experiences, as they were so excruciatingly described to us, mirrored the experiences of incest and rape victims. In fact, many abused patients do describe their experiences of abuse with doctors as physical, psychological, and spiritual rape. The majority of survivors emphasized that their victimizations were particularly damaging and devastating because their doctors were placed in a position of absolute trust.

It is not something we, like these victims, can easily forget.

The elements of trust, hope, and belief are the bedrock to a therapeutic alliance and to the doctor/patient relationship. Both are essential for the healing process.

Briar Long, Coordinator



Briar Long used her honours B.A. from the School of Business, University of Western Ontario, in her work as a senior account director with a major Canadian advertising firm; and as a research consultant in stress management and recovery from abuse. Briar's expertise in project management and writing and editing proved to be crucial to the Task Force and is now being directed to a career in medicine.

I came to the Task Force in a period of personal transition - moving from a senior position in the advertising business towards a career in the helping professions, possibly as a doctor. It has been a pleasure to work with the dedicated, caring individuals on the Task Force. I have learned a great deal about the devastation caused by sexual abuse, the ways that existing systems discriminate against survivors, and how difficult it can be to change the status quo.

My personal experience, after listening to many, many survivors of sexual abuse by physicians and reviewing the feedback to our Preliminary Report, has been to be struck by the significance of the pain, anguish, anger, and betrayal experienced by survivors and the broad-reaching ways the abuse has affected them.

I have also been struck, however, by the tremendous capacity of the human spirit to recover from these devastating effects - when the right supports and resources are in place. I have been inspired by the strong fighting spirit in many of these survivors and in those who work as advocates on their behalf.

It is my sincere hope that those reading our Report will be able to accept the truth and the importance of what we are saying. I also hope that those in a position to change things for the better will take the brave, first steps to do so.

Bonnie Homeniuk, Technical Coordinator

Bonnie Homeniuk has a B.A. in Sociology and English from the University of Alberta. In the past three years, she has pursued freelance work in educational and humanistic environments. Previous projects have included editorial and technical writing for health care and private organizations.



Until becoming a part of the Task Force team, I had never been involved with the issue of patient sexual abuse of patients. Nor had I worked on such a serious project that had such far-reaching potential. This is one project I will not forget.

It was a pleasure and an honour for me to work with the other Task Force members on this important issue. I only hope that the amount of hard work I've seen go into the production of both Reports will result in much needed change in the profession.

MANDATE: Task Force on Sexual Abuse of Patients

The CPSO has identified the sexual abuse of patients as a serious problem which must be addressed in part by establishing this unprecedented Task Force with a majority of members who are not doctors.

The Task Force has the mandate to seek information from the public, the College and individual doctors through public and private hearings in various cities in Ontario in February and March. When requested, presentations may be heard only by Task Force Members of the same sex as the presenter.

The Task Force will be assisted by an Advisory Council with diverse representation to provide information and guidance in preparing the Preliminary Report to be released to the public and the College on May 27, 1991. The Task Force will be guided by its terms of reference and will recommend:

- improvements to College policies and procedures related to sexual abuse complaints;
- changes to relevant legislation and legal practises;
- guidelines for doctors with patients and former patients;
- educational initiatives for doctors and the public.

Adopted by CPSO Council January 28, 1991

TERMS OF REFERENCE: Task Force on Sexual Abuse of Patients

1. To establish guidelines for conducting the Task Force and its public hearings and to ensure liaison with members of the CPSO.

2. To establish an Advisory Council to the Task Force. The Advisory Council will meet monthly with the Task Force and will have a diverse membership to increase opportunities for informing the Task Force.

3. To develop a philosophy for the College in dealing with complaints involving sexual abuse.

4. To review the effectiveness of the College's policies, practices and procedures in dealing with sexual abuse.

5. To review issues relating to open/closed discipline hearings from the perspective of the College, the doctor and the complainant, and to refine the criteria for conducting hearings using the **Health Disciplines Act**, the **Statutory Powers Procedures Act** and the proposed Health Professions Legislation as starting points.

6. To review judicial decisions and legislation to determine whether recommendations for law reform should be made.

7. To review the situation of complainants whose complaints of sexual impropriety have been dismissed and/or who express dissatisfaction with the process, to consult complainants and others, and to recommend:

    a) improvements to investigations for complaints of sexual impropriety;
    b) improvements to hearings of such complaints;
    c) how to reduce delays in the processing of such complaints;
    d) how the College could provide appropriate support throughout and following the discipline process.

8. To develop criteria for:

    a) appointment of prosecuting counsel;
    b) membership on discipline panels.

9. To recommend when limitations on the practices of members are appropriate including:

    a) after a determination of guilt;
    b) prior to sentencing;
    c) during any appeal of a College or court decision.

10. To recommend guidelines for doctors regarding:

    a) personal romantic involvement with former patients;
    b) how to assist patients who have been sexually abused;
    c) reporting of a patient's allegation of sexual abuse against another doctor.

11. To recommend educational initiatives for doctors (at all levels of training) and for the public.

Adopted by CPSO Council January 28, 1991

EXECUTIVE SUMMARY

A Time for Leadership

The essence of the relationship between doctor and patient is trust. When this trust is abused, the results are devastating - devastating for the victim, usually in many aspects of her* life, for the families affected, and for the trust we place in the medical profession. For society as a whole, it is an act of trust to grant self-regulation to a profession, relying on the profession's leadership to govern itself in the public interest.

"In sexual abuse cases, behaviour is often construed by the courts as consensual when it is compliant, exacted through the threat of further harm, the abuse of unequal power or exercise of authority."

(METRAC - August, 1990)

Over the life of the Task Force, we have heard a great deal about this trust and the ways it is abused. We have heard from patients, from doctors, from advocacy groups, and from institutions such as the College. We have met with individuals in our public and private hearings to listen to concerns and experiences of sexual abuse by doctors, and to hear feedback on our Preliminary Report. Over seven months, we heard 303 detailed reports of sexual abuse by physicians and others in a position of trust (61 through our public and private hearings, 203 through phone calls to our confidential telephone line, and 39 through letters). Twenty-six of the reports were third-party reports. Sixteen reports involved sexual abuse of male patients.

The College of Physicians and Surgeons took a crucial leadership role in creating this Task Force in January of this year, and in publicly acknowledging that great change is necessary to deal with sexual abuse. It has assumed this mantle of leadership in a society with such a deficient and confused understanding of sexual abuse by those in positions of trust that it cannot look to traditional sources of leadership for models. Medical educators are not leading the way. Judges are not leading the way. There is no evidence that other professions in Canada are regulating appropriately in this area.

On May 27, 1991, the Council of the College adopted the Task Force's recommended philosophy, in passing a motion confirming "the College's commitment to the safety of the public by affirming the philosophy of **Zero Tolerance** of sexual abuse, and in accordance with that philosophy, developing policies, procedures, practices, and education programmes that support it." (Recommendation 1 of the Preliminary Report).



Sylvia Bradley, presenter, public hearing

**Note: Because nearly all perpetrators of sexual abuse are male and the great majority of victims are female, and because analysis of the still-prevalent mythology of sexual abuse reveals it is not a gender neutral crime, words in the masculine gender will be used in this report to refer to perpetrators of sexual abuse and (except where an individual victim is male) words in the feminine gender will be used to refer to victims.*

The Government of Ontario is in the final stages of enacting legislation to replace the existing **Health Disciplines Act**, to be named the **Regulated Health Professions Act** (RHPA). The Minister of Health, the Honourable Frances Lankin, recognized the leadership of the College in her statement to the House that the Ministry of Health would have a policy of **Zero Tolerance**. The Minister went on to state clearly that it was her goal "to enact a law that will deter sexual abuse, bring abusers to justice and treat victims with greater sensitivity and respect." It is significant to note that our Preliminary Report has been supported through references to it by members of all three political parties.

"Sexual intimacy is never, ever, a therapeutic interaction. They cannot be combined."

Dr. Eleanor Schumacher, Windsor, Public Hearing

We believe the College must continue to create innovative procedures and practices internally and to be an instigator of change externally.

Is Sexual Abuse a Breach of Trust?

Patients seek the help of doctors when they are in a vulnerable state - when they are sick, when they are needy, when they are uncertain about what needs to be done.

The unequal distribution of power in the physician-patient relationship makes opportunities for sexual exploitation more possible than in other relationships. This vulnerability gives physicians the power to exact sexual compliance. Physical force or weapons are not necessary because the physician's power comes from having the knowledge and being trusted by patients.

Many doctors who responded to the Preliminary Report questioned whether doctors should be held to the highest standard of accountability generated by the philosophy of **Zero Tolerance.** Doctors do have power over their patients. Doctors, by law, must be members of the College, which, in turn, has a statutory "duty to serve and protect the public interest" (RHPA Procedural Code). The College has been entrusted with the exclusive right to determine who may have the privilege to practise medicine in Ontario. In return for the special rights, powers and privileges given to self-regulating professions, society expects these professions and their members to place the interests they are appointed to protect above their own interests (METRAC, 1991). When this does not happen, it is breach of trust.

"Most Women become addicted through the medical prescription drug route and I would suggest that victims of sexual abuse are particularly vulnerable to this disturbing problem of sexual enslavement."

Dr. Elaine Borins, Toronto, letter to the Task Force

It is well recognized that the nature of the trust between lawyers and their clients creates a fiduciary duty of trust. Fiduciary duty is recognized in law as having the highest standards of conduct and when breached, severe consequences are warranted. When lawyers breach fiduciary trust by taking a client's money wrongfully, lawyers are disbarred. Doctors, as well as lawyers, enjoy special status and bear special responsibility derived from their position within their profession. When doctors take advantage of that position to commit sexual abuse, they breach the fiduciary trust; adding a further dimension to the wrong done to the victim.

Consistent with the Supreme Court of Canada* decisions in Guerin (1984) and Lac Minerals Ltd. (1989), the Ontario High Court recently stated this definition:

> "Where a fiduciary relationship exists, the fiduciary has a paramount duty of loyalty. A fiduciary cannot permit a conflict between the interest of his beneficiary and any other interest, especially his own. A fiduciary may not obtain a profit, benefit, or advantage as a result of his position."
>
> - Ontex Resources Ltd. v. Metalore Resources Ltd. (1991)*

"There are good and ancient reasons for a sex taboo in therapy. It is not a relationship of equals. There is a carryover of the incest taboo. Exploitation of the patient is a real possibility. And therapy - not sex - is the business of the therapist. ...I remain unconvinced that any therapist has ever produced an erection for therapeutic reasons".

Dr. Jules Older, 1977 Four Taboos That May Limit the Success of Psychotherapy, 40 Psychiatry (1977) 196, 198

What Constitutes Sexual Abuse?

Sexual abuse of patients can take many forms. It can involve rape and forced violations of breasts and genitals. It can involve the physician using his position of power to gain sexual access to a patient by representing sex as part of treatment. It can involve the development of personal sexual relationships to meet the needs of the physician. During the course of our work, many survivors shared their painful experiences of just such violations with us, many speaking up for the first time. (see Chapter 1, Voices: A Sampling)

The relationship between psychotherapist/physician and patient is one in which the patient is particularly vulnerable to abuse. The dynamics of that relationship, due to the powerful impact of transference and counter-transference, resemble the parent-child relationship, putting the physician in a position of great power. Experiencing sexual feelings on the part of either patient or physician/therapist may be a "normal" outcome of the psychotherapeutic process, creating opportunities for abuse unless appropriate boundaries are set and kept clear. Those in psychiatric treatment in particular are at risk of being labelled with diagnoses such as "borderline personality," which are often used to invalidate their claims of abuse.

Due to the position of power the physician brings to the doctor-patient relationship, there are NO circumstances - NONE - in which sexual activity between a physician and a patient is acceptable. Sexual activity between a patient and a doctor ALWAYS represents sexual abuse, regardless of what rationalization or belief system the doctor chooses to use to excuse it. Doctors need to recognize that they have power and status, and that there may be times when a patient will test the boundaries between them. It is ALWAYS the doctor's responsibility to know what is appropriate and never to cross the line into sexual activity.

**At the time of writing this report (November 1991), the Supreme Court of Canada had not yet released its decision in the case of Norberg v. Wynrib, which is expected to clarify the fiduciary trust in the doctor-patient relationship (see Legal Appendix).*

What is the Prevalence of Sexual Abuse by Physicians?

Sexual contact between physicians and patients is not new..nor are efforts to stop or prevent it. Since the earliest written reference to physician-patient sex, in the Corpus Hippocratum (4th and 5th centuries B.C.), the medical literature has reflected physicians' concerns about the damaging effects of sexual contact with patients.

"He chose to do me harm at a critical turning point in my life. I fled from that psychiatrist, and didn't go near anyone for 10 years until I finally saw a woman psychiatrist, who asked me:
"Is there any chance you could be imagining this?[tears]

A Woman Lawyer, Private Hearing

Because physician-patient contact has not been a research priority, traditional scientific evidence of sexual abuse by physicians is limited. The Canadian book by Lapierre and Valiquette, J'ai Fait L'amour Avec Mon Thérapeute, published in 1989, documents interviews with 83 women and 16 men (3 of them calling about their wives), providing case examples of sexual abuse by psychiatrists and therapists. There are four U.S. studies which are self-reporting surveys with samples which include psychiatrists, obstetrician-gynaecologists, surgeons, internists, and general practitioners. These studies place the incidence of sexual or erotic contact of physicians with patients at 7-13 % of physicians.

The U.S. studies are consistent with the results of a recent survey conducted by Canada Health Monitor and Price Waterhouse Management Consultants, in which 8% of Ontario women reported sexual harassment or abuse by doctors. The survey, expected to be accurate within plus or minus 2.7 percentage points, 19 times out of 20, was the first of its kind in Canada, and the first to report on physician-patient sexual contact from the patient's point of view.

Regardless of the scientific evidence, however, the number of reports of sexual abuse by physicians that have come to the Task Force in only six months indicates a serious problem, particularly when considered with evidence that, on average, only one in ten victims of sexual assault comes forward. Based on the information that has come to the Task Force, it is no longer conceivable to consider that sexual abuse by physicians is a rare, bizarre, or isolated incident.

There is sufficient evidence to establish that sexual abuse by physicians is a problem, that it is happening frequently, and that it needs to be dealt with urgently. We should not let alarm or scepticism about incidence levels, or the small number of scientific studies, divert us from the need to take action.

"The doctor told me that I could never afford to go after him, that he had insurance, and that it covered a lawyer, and that I would lose everything, including my farm."

A Man Whose Wife was Abused, Private Hearing

Why We Believe the Reports of Abuse

We met with many survivors of physician sexual abuse in the course of our work. The pain, shame, anger and violation these patients felt around the experiences they told us about were very real.

Many have questioned us on how we can believe these reports of abuse. False allegations of sexual abuse are rare. Police statistics show that only 3% of reports of sexual abuse are false, about the same as false reports of other crimes. In fact, the real issue in sexual abuse is under-reporting. The

shame, anger, and self-blame experienced by survivors of sexual abuse and the fear of not being believed are powerful deterrents to coming forward. Canadian victimization surveys show that only 10-40% of those who are sexually abused ever report what happened to them.

What is the Actual Harm?

The actual harm to those who have been sexually abused by physicians is serious and considerable. Victims rarely show direct physical signs of the abuse, but the emotional injury is significant and far-reaching, and the damage often manifests in physical health problems as well. In addition to not receiving help with whatever brought them into treatment originally, those who have suffered even one episode of abuse have had their boundaries breached and their trust betrayed. Often, family members and others close to the victim are harmed and require treatment as well.

Health problems which follow sexual abuse of adolescent or adult women include intense anxiety, fear, panic, depression, suicidal feelings, loss of trust in the world and society (which may present as paranoid suspicions), difficulty in developing or maintaining an intimate relationship, difficulty in sexual relationships, flashbacks, nightmares and sleep disorders, and painful re-triggering of memories of childhood sexual abuse or previous acquaintance or stranger assault.

Patients who have been sexually abused may also present with a wide variety of physical symptoms, including abdominal pain, pelvic pain, gastro-intestinal tract problems, headaches, eating disorders, or drug and alcohol abuse.

Many patients cease to be able to trust doctors or health care providers again. The experience of sexual abuse in the examination room is so powerful and humiliating that they may avoid further medical care or travel hundreds of miles to get medical care that feels comfortable to them.

"Doctors can't do damage control unless they know what the damage is."

Dr. Marcellina Mian, Public Hearing, Toronto

The societal impact of sexual abuse by physicians is not without consequence either. Survivors reported to us that abuse had caused them to drop out of school, or not pursue educational opportunities, blocked their ability to have satisfying relationships, contributed to family breakdown, and prevented them from being able to parent effectively, to work, or to thrive.

The Reality of Risk of Harm

As part of its mandate to protect the public, the College must look not only at the **actual harm** caused by sexual abuse by physicians but also at the **risk of harm** to other patients posed by such physicians. We have found that this risk of harm is rarely identified and profoundly underestimated when it **is** named.

Existing research, together with information that came to the Task Force from survivors and experts in the field, identifies that there is a significant

risk that a physician who abuses one person will abuse others. This means that many patients of an abusing physician are at risk, even if only one patient has been able and courageous enough to complain.

It is important that policies, practices, and procedures designed to deal with sexual abuse by physicians provide **safeguards** against this risk of harm at any time when there is an allegation and strong evidence of sexual abuse, and certainly on a finding of guilt.

The Philosophy of Zero Tolerance

We believe it is necessary to have a clear standard by which to measure the appropriateness of policies, practices, procedures and education programmes designed to deal with sexually abusing physicians. **Zero Tolerance** provides that standard.

Zero Tolerance establishes that sexual abuse of patients by physicians is never acceptable and must not be tolerated in our society. It recognizes the seriousness and extent of injury abuse causes, the **risk of harm** posed by abusers, and the need for realistic and effective standards of rehabilitation.

Zero Tolerance means that:

- We do not tolerate sexual abuse by physicians.
- We do not tolerate the ways sexual abuse by physicians is **implicitly** supported.
- We work towards the development of sufficient support for victims so that they **can** come forward and they **can** heal.
- We work diligently towards educating doctors **and** the public about appropriate behaviour and attitudes, so abuse cannot occur out of ignorance on the part of either doctor or patient.
- We continue to support touch as a crucial, healing part of the practice of medicine, when that touch is caring, nurturing, and not sexual, exploitative.

Zero Tolerance does **not** mean making a pre-judgement that any doctor accused of sexual abuse is automatically guilty, or setting up systems at the College or elsewhere that deny "due process" to doctors. Rather, it means we balance the rights of doctors with the rights of patients and the safety of the public.

We believe that **Zero Tolerance** is the only appropriate philosophy regarding sexual abuse of patients for several reasons:

- Sexual abuse by physicians inflicts serious, long-term injury to the victim, both physical and emotional.

- It is particularly harmful in that the abuse of the patient's original trust makes it difficult, if not impossible, for the victim to place her

trust in doctors or other caregivers again; providing a major obstacle to getting the care needed to recover.

- Sexual abuse by physicians tarnishes public trust in the whole profession, including the majority of physicians who **are** providing caring, appropriate care.

- Finally, **Zero Tolerance** is the **only** philosophy consistent with protecting the public, the goal of self-regulation of physicians.

The concept of **Zero Tolerance** of sexual abuse, which originated through Task force member Pat Marshall's work with METRAC, was widely supported by patients, doctors, and advocates everywhere we held hearings.

"Survivors of sexual abuse show remarkable courage when they are able to tell their stories. Physicians must learn from the courage of these survivors. We should support the College of Physicians and Surgeons of Ontario as they try to face the problem. We must find the integrity, not only to speak up against perpetrators, but to censure other organizations that deny the reality of sexual abuse. We must learn about the dynamics of sexual abuse by asking our patients about it, hearing their replies, and by supporting them. The victims of sexual abuse have been in their own dark prison long enough - let's help them into the light."

Dr. Carole Clapperton
President, Ontario College of Family Physicians

Does Zero Tolerance Mean the End to Caring Physical Contact with Patients?

The value of nurturing, supportive physical contact with patients, such as holding a patient's hand in times of pain, or a reassuring touch, is well-established and an important part of good patient care. The philosophy of **Zero Tolerance** is **not** intended to discourage it or eliminate it, and need not do so if physician and patient talk about whether such touch feels appropriate to the patient.

Physicians and patients, including children, know the difference between caring and exploitative relations, "good" and "bad" touch, sexual and non-sexual contact. However, even if a patient attempts to sexualize the relationship, the onus is always on the physician not to cross that line. The philosophy of **Zero Tolerance** is designed to make it easier for both physician and patient to feel confident about what kind of touch is appropriate because of the increased level of clarity the philosophy provides.

Education for Physicians, The Public, and The College

We believe that education for physicians, the College, and the public is one of the pivotal elements to successfully implementing the **Zero Tolerance** philosophy. There is much that can and needs to be done to ensure that episodes of patient sexual abuse are not due to ignorance of either the physician or the patient and that survivors get the care and information they need to recover.

Education for Physicians

We heard over and over of the difficulties experienced by survivors of sexual abuse by physicians in finding the treatment they needed to recover. Many survivors, once they felt ready to try trusting a caregiver again, had difficulty finding someone willing to help with this kind of abuse and to give them the support, validation, and care they needed to recover. Often, well-meaning physicians were willing and tried to help, but they lacked the skills

required and the treatment was of little value. Survivors who had their memories of the abuse blocked (a common way the psyche defends itself from trauma) and presented with physical or emotional symptoms were often misdiagnosed because the underlying cause of sexual abuse was missed, and treatment was inappropriate or unhelpful. These issues are symptomatic of the need for more education about how to effectively help survivors of sexual abuse generally, as well as how to help survivors of sexual abuse involving a breach of trust.

"The CPSO relies on and expects the leaders and educators in Psychiatry and Family Medicine to make their members aware of this issue and to educate residents on the impropriety of physician-patient personal/sexual relationships. As you can see by the briefing paper from an American study, only 12.1% of final year psychiatry residents believe that they had received a thorough education on physician/patient sexual contact. Of serious concern to all physicians must be the revelation that almost 8% of male and 2.2 % of female psychiatrists in one study (Washington) had had sexual contact with their patients. This becomes magnified in the recognition that there is a 75-80% chance of it being repeated."

Gary G. Johnson, M.D., University of Ottawa Representative to CPSO Council

In addition to the need for more training in how to recognize and treat survivors of sexual abuse effectively, our consultations with the medical profession, advocacy groups, and others who help survivors of sexual abuse have identified needs in a number of other areas:

- Greater understanding by physicians of the context in which sexual abuse and sexual abuse by physicians occurs.
- Gender socialization, the tolerance of violence against the less powerful in our society, and the inequality of power in the physician-patient relationship.
- Greater comfort with and awareness of their own sexuality and human sexuality generally, on the part of physicians.
- Training on trust issues and how to set and enforce appropriate treatment boundaries with patients, particularly when treating survivors of sexual abuse.
- Training for physicians on how to recognize signs in their own behaviour that they may be heading towards sexual abuse of patients, and what needs to be done to prevent themselves from abusing
- Training for medical educators to improve role-modelling, emphasizing the importance of not breaching the trust inherent in the faculty-student relationship.

Therefore, we are recommending a number of changes in physician education, to take place for physicians at all levels of training. We are further recommending that this training be included in examinations and accreditations throughout training and practice (Recommendation 2).

We believe there are also a number of guiding principles that physicians must become aware of immediately, and we are recommending that the College move swiftly to ensure these are known (Recommendations 3, 26):

- That, due to the power the physician brings to the physician-patient relationship, there is no such thing as gaining consent for sexual involvement with a patient.
- The warning signs of behaviour that indicates that sexual involvement with patients may occur, and what to do to prevent abusing.

- That the physician has the right to refuse to examine any area of the body of a patient or to terminate the relationship if the physician feels that the patient is sexualizing the relationship, and how to terminate it appropriately.

- Where survivors of sexual abuse can find effective treatment.

- The physician's legal obligation to report sexual abuse by another physician (as proposed in Recommendations 15-19).

- The nature of sexual impropriety and sexual violaton, as outlined in Recommendation 24.

Education for the Public

We are recommending a number of initiatives to ensure the public is better informed on issues relevant to preventing and addressing sexual abuse by physicians (Recommendations 7-8). The following needs are evident:

- Better knowledge of appropriate examinations, as well as behaviours that are inappropriate. We found that lack of knowledge in these areas was a factor in the confusion experienced by survivors of abuse and could lead to delays in disclosing and reporting.

- Awareness of behaviours that are warning signals to pending abuse. There are often such warning signals. Better understanding of these will contribute to prevention of some types of abuse.

- The need for patients, particularly survivors of abuse reaching out for treatment, to feel that a physician's office is a safe place and that they have some power in the physician-patient relationship. The recommended "Physician's Commitment to Patients" statement is designed to offer this reassurance and provide a basis for discussion between doctor and patient about the patient's right to be an active participant in the planning of his or her health care treatment (for a draft of this "Physician's Commitment to Patients" statement, see Chapter 3)

- Greater awareness of the College, its role in protecting the public, and the existence of a complaints procedure. Many survivors were unaware of the College and felt they had few or no options for redress or for preventing their abuser from harming others.

Education for the College

We are also recommending training for every individual at the College who may have contact with someone inquiring or complaining about sexual abuse, as a way to build required understanding of the issue at the College, and facilitate an increased level of reporting and a less traumatizing process

for complainants (Recommendation 27). In addition to what the College has already accomplished in this area, there needs to be substantive, ongoing training in:

- The nature of sexual abuse by physicians, the consequences to victims and issues of gender, race, and class related to abuse

- The range of ways a survivor may initiate inquiry or disclosure, and how to handle inquiries, disclosures, complaints, and information dissemination in an appropriate, supportive, and empathetic manner.

Joint Ventures in Education

We are recommending that many of the educational initiatives be accomplished by a series of innovative joint ventures (Recommendations 4-6). The initiatives required are beyond the scope and mandate of the College alone. Joint ventures are required to gather the range of perspectives and expertise to create truly effective change. They will lead to more thorough understanding of the issues involved and more efficient use of resources through the synergy created and the avoidance of working at cross-purposes. The joint ventures are:

1. A new **Joint Education Committee on Sexual Abuse** to develop and implement the necessary changes in physician education. Membership on this Joint Education Committee is to include senior representatives of government, the medical community, and front-line advocacy organizations.

   A progress report from the Joint Education Committee is required to be presented to the annual general meeting of **each** of the membership organizations and to the **Minister of Health** each year for the next 3 years, beginning in 1992.

2. A clear and ongoing liaison between the College, the committee Planning Education of Future Physicians of Ontario (EFPO), and the Council of Faculties of Medicine, to help facilitate change in undergraduate medical education in particular. A representative of the College to take responsibility for ensuring that progress reports be made to the Joint Education Committee.

3. A co-operative effort by the College, the Law Society of Upper Canada, and the Metro Action Committee on Violence against Women and Children (METRAC) to develop a continuing education program for lawyers geared to the effective investigation and prosecution of sexual abuse complaints against physicians and health care providers. Only lawyers who have completed the course would be eligible for selection as prosecutors of sexual abuse complaints at the College. (This proposal is already in the planning stages by the College, the Law Society, and METRAC).

"Going to a doctor should not generate any of the baggage of volunteering for 'The Dating Game.' The only issue in going to a doctor should be the patient's best interest."

Professor Robert Solomon, Faculty of Law, University of Western Ontario

Guidelines for Doctors on Involvement with Former Patients

As required by our Terms of Reference, we are recommending specific guidelines for doctors on sexual involvement with former patients. It is important to note that at this time we are recommending guidelines rather than statutory amendments. Many doctors reported to the Task Force considerable confusion as to what constitute guidelines which the College expects them to follow. We are recommending that the College immediately compile a complete list of all guidelines issued by the College and include on that list the guidelines in Recommendations 10 and 11. These guidelines are designed to prevent sexual abuse that arises from exploitation of emotions developed in the doctor-patient relationship, and are based on an examination of when that relationship ceases to be one of unequal power. Specifically, we are recommending (Recommendations 10, 11):

- A two year time lapse after the last professional (doctor-patient) contact before sexual involvement is appropriate. Research has shown that this time period is effective in eliminating those relationships where the involvement is damaging.

- In cases where the doctor-patient relationship was primarily for psychotherapy, a prohibition on sexual involvement at **any** time after professional contact, due to the powerful, lasting nature of transference, the power imbalance it create, and the fact that after terminating, patients often return for further therapy several times over many years.

"It is important to ensure that the strength of the voices heard throughout this process continue to resonate. This can only happen through consistent and tenacious monitoring of the implementation of the recommendations in subsequent years."

Roma Reses, M.S.W., Women's Health Care Center, Peterborough Civic Hospital

We are also recommending the establishment of a Guidelines Committee to examine models from other jurisdictions and determine whether statutory amendments are needed (Recommendation 12). It is important to note that, based on our legal research, we have concluded that no legal rights of doctors would be infringed even if the guidelines were made into statutory amendments. This Committee should not be seen as an authority which approves or exempts physician's choices to have sexual contact with former patients, nor should it be confused with the new Committee on Patient Relations to be established by every College as recently announced by the Minister of Health.

Implementation and Monitoring

Our Preliminary Report recommended that implementation of the **Zero Tolerance** philosophy should take place in <u>all</u> self-regulated health professions under the new **Regulated Health Professions Act** (Preliminary Recommendation 55). We also recommended that implementation be monitored for the next three years with a report to the Minister of Health from an Evaluation Team in 1994 recommending whether or not the College should retain the right to self-regulate in matters of sexual abuse (Preliminary Recommendation 13).

The Task Force made a presentation to the Standing Committee which is reviewing the new RHPA urging that action be taken even before the release

of our Final Report. On September 23, 1991, the Parliamentary Assistant to the Minister of Health announced to the Standing Committee that:

> "We believe we can take some action immediately. ...
>
> So immediately upon release of the Final Report now scheduled for late November, an **Interministerial Working Group** will conduct a consultation with all interested professional groups and public interest groups. We hope a consensus will emerge from this consultation though we recognize it may be necessary to make unpopular decisions and are prepared to do so.



Jim Curtis, a physician member of the governing Council of the College, with Marilou McPhedran at a meeting of the Task Force Advisory Council

We are proposing the creation of a new statutory committee, the **Patient Relations Committee**, and will be requiring **every College** to institute a program aimed at preventing sexual misconduct within one year of proclamation of the bills [RHPA]. The effectiveness of each College's program will be evaluated by a **Monitoring Board** composed of members of the public and representatives of the professions. The **Monitoring Board** will be required to make an annual report which must form part of the annual report of the College that is tabled in the legislature." (Paul Wessenger, Parliamentary Assistant to the Honourable Frances Lankin).

Lack of faith in the College's ability to self-regulate effectively was one of the clearest messages we received from our hearings. The public, particularly those who have approached the College for help, perceived it as a self-serving organization which protects the doctors.

We believe that as a result of this perception few complaints of sexual abuse reach the College discipline process. In 11 years, only 44 sexual abuse cases proceeded to a Discipline hearing at the College. There were 27 findings of professional misconduct, 14 findings of not guilty, and 3 cases withdrawn.

Between 1987 and early 1991, before the formation of the Task Force, 150 reports of sexual abuse were made to the College. In comparison, in the nine months since the Task Force has operated (February 1991 - November 1991), 149 reports have been made.

The extent of the dissatisfaction with the College's ability to self-regulate is so great that many presenters urged us to remove the power to self-regulate from the College and to give it an independent tribunal which would be appointed for its demonstrated expertise in dealing effectively with sexual abuse.

However, the Task Force believes, based on the recent acknowledgement by the College of the need to improve its practices, that a further test of self-regulation is reasonable. We continue to recommend that an assessment of the ability to self-regulate be made again in three years (1994).

We are also recommending that, within the College, an **Implementation Committee** be established immediately, to be made up of representatives from College Council and staff at all levels, and, to utilize their developed expertise, to include at least three representatives from the Task Force or the Advisory Council. The Implementation Committee would present a detailed progress report to the public, the Minister of Health and the College Council at the CPSO Annual General Meeting in 1992, 1993, and 1994 (Recommendation 1(a)).

Reporting

Consistent with the philosophy of **Zero Tolerance**, we are recommending the initiation of mandatory reporting of physician sexual abuse by physicians and the establishment of a firm policy of accepting **third party reports** (Recommendations 15-19). Our approach is based on the model currently in use in Minnesota, and is similar to existing Canadian requirements for reporting child abuse (**Child and Family Services Act**, Section 68). The approach has these essential features:

- All physicians would be obliged to report any knowledge or reports of sexual abuse by another physician to the College.

- Third-party reports may also be filed and the information must be recorded by the College.

- The acceptance of a report by the College would not trigger an investigation, unless the patient initiated a formal complaint.

- Such reports would include the reporter's name, if they so agree, and the alleged offender's name. The patient's name would be included only if the patient so agreed in writing, so that the patient retains the option of deciding when a formal complaint, and hence investigation, would be initiated.

- When the College had received more than one such report, it would trigger a review of the evidence and the College would determine whether there were reasonable grounds to start an investigation.

- Anyone who reports in good faith and on reasonable grounds is immune from civil liability for making the report.

- This process would not annul existing legislative safeguards of "due process" in the system.

We found it was common for physicians and others to have knowledge that physicians were abusing and to do nothing with that knowledge, or to

try to pass the information on to the College and have it refused unless the patient would launch a formal complaint. The recommended system is designed to ensure that knowledge of sexual abuse reaches the College and is not lost. The deletion of the patient's name ensures the patient is not forced to participate in the traumatic investigative process until she is ready. However, should an investigation be initiated based on other reports, the College is able to contact her later, through the reporter, to see if she may be able to assist in the investigation.

As a further safeguard to ensure that the College can protect the public from abusers, we are also recommending:

- That physicians be obliged to report to the College, as a condition of licence, any criminal convictions related to sexual offences against them, or the initiation of any civil suits against them that involve alleged sexual impropriety or sexual violation, and that the College check previous licensing bodies of the applicant physician for such charges prior to granting a licence.

- That police forces be obliged to report to the College any criminal charges laid against physicians, and that the College be obliged to report to police when a physician has been found guilty of sexual violation or sexual impropriety.

- That the College report physicians guilty of sexual violation to other Colleges of Physicians in Canada and other related professional bodies in Canada and submit the report to the Board Action Data Bank in Fort Worth, Texas.

The present system...is seen by victims as a system that is run by doctors, that is controlled by doctors, and which exists for doctors. It is seen with considerable accuracy as a system in which the victim is a mere witness,...in which only the doctors have rights. The victim has none - none whatsoever. The doctors decide whether there will be a hearing. There is no right to have a hearing. The doctors will then sit as judges, in the course of the hearing, and will determine...what evidence will be called at the hearing. All the control is there, on that side. There is nothing for the victim."

Anne Molloy, Legal Counsel, Advocacy Resource Centre for the Handicapped

Penalties for Abusing

We are advocating a commitment to eradicating all forms of sexual abuse in a way that is sensitive to the patient's experience of it. We also believe that self-regulation can be improved significantly by making a distinction in forms of sexual abuse for penalty consideration, and by defining more clearly what behaviour constitutes the offences. The two levels we are recommending are:

I. **Sexual Impropriety** will comprise any behaviour, gestures, or expressions that are seductive or sexually-demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing or draping practices that reflect a lack of respect for the patient's privacy, (or) deliberately watching a patient dress or undress, instead of providing privacy for disrobing; subjecting a patient to an examination in the presence of medical students or other parties without the explicit consent of the patient or when consent has been withdrawn; and examination or touching of genitals without the use of gloves; inappropriate comments about or to the patient, including, but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually-demeaning comments to a patient, criticism of the patient's sexual orientation

(homosexual or heterosexual or bisexual), making comments about potential sexual performance during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction, requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation and making a request to date; initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physicians; kissing of a sexual nature.

The penalty reange for Sexual Impropriety would include reprimand, apology, fine, temporary suspension of licence with conditions or any combination thereof.

II. **Sexual Violation** will include physician-patient sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may be reasonably interpreted as sexual, including, but not limited to: sexual intercourse; genital to genital contact; oral to genital contact; oral to anal contact; oral tooral contact except CPR; touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment or where the patient has refused or has withdrawn consent; encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present.

The penalty for Sexual Violation would be a mandatory revocation of licence for a minimum of five years and a fine up to $20,000.00.

These changes will require amendments to the **Health Disciplines Act**, or its successor, the **Regulated Health Professions Act**.

Automatic revocation of licence for a mandatory minimum of 5 years for sexual violation is a severe penalty, and is consistent with a philosophy of **Zero Tolerance**. We believe it is appropriate for several reasons. A physician who has sexually abused has committed an act that has caused serious harm to his patient. He has totally disregarded the well-being of the patient to serve his own needs. He has seriously betrayed the absolutely fundamental trust we place in him as a doctor, damaging not only the patient but the integrity of his profession. Further, such a penalty is appropriate at a time when rehabilitation programmes for sexual abusers are not developed to the extent required to ensure an abuser no longer poses any **risk of harm** to the public. Limitations on practice (such as supervision or a restricted practice), proposed as an alternative to revocation, have not proven to be effective protections against the re-occurrence of abuse.

A permanent revocation of licence is not the removal of any right the physician may have to livelihood, particularly given the level of education physicians have. In 1988, the Ontario Court of Appeal clearly stated:

> "there is no constitutional right to practise medicine"
> Re: Jamorski (1988), 64 O.R. (2d) 161 at 168.

Rather, it is the removal of the **privilege** of practising medicine and the **privilege** of receiving the public's highest level of trust.

We are also recommending that the College, as part of the discipline hearing, should present evidence that sexual violation is not just misconduct but is also an issue of competence related to Standards of Practice.

This is an important shift in approach because when a doctor is found to be incompetent under S.60(4) of the present **Health Disciplines Act**, the decision of the Discipline Committee takes effect immediately, regardless of whether an appeal is taken from the decision. This will reduce the **risk of harm** to other patients because the doctor cannot continue to practise while the appeal is in process.

The current practice of naming sexual abuse as "impropriety" to be punished only as "misconduct" furthers the trivialization often experienced by survivors and already evident in judicial decisions and some College decisions.

A physician who is sexually abusing a patient is not giving competent care.

The Debate About Rehabilitation

"If rehabilitation is going to work, then you have to remove [the abuser] from the source of the temptation. If you're treating an alcoholic, the last thing you want to do is put [him back] in a job at a local bar. The same principle goes for doctors guilty of sexual abuse."

Dr. William Marshall, Director, Sexual Behaviour Clinic, Kingston

The Task Force has listened to significant debate about whether or not physicians who sexually abuse can be rehabilitated. We have heard from a number of experts in the field of rehabilitation. We also met with survivors of sexual abuse whose physician-abusers had been disciplined by the College and pronounced "rehabilitated," only to abuse again.

The mandate of the College is to protect the public. Therefore, the perspective in which rehabilitation must be reviewed is not whether or not an abuser is "treatable" or entitled to rehabilitation. Rather, the issue is whether rehabilitation can be successful and extensive enough to return him to practice without **risk of harm** to future patients. This implies a very high standard of certainty that the abuser will not abuse again.

Currently there is no research that specifically looks at the effectiveness of rehabilitation of physicians who have sexually abused. Studies of abusers in general show abusers who are treated are less likely to re-abuse than those who aren't, but it is extremely difficult to predict who will and who won't reabuse, and many abuse again.

Much of the rehabilitation effort goes into relapse prevention, based on teaching an abuser to recognize high risk situations and avoid them. To return an abusing physician to practice is to place him back in a high risk situation, with high potential for relapse.

The Task Force has concluded that, given the primitive state of rehabilitation today, the risk of harm in returning an abusing physician to practice is significant, even if he has had extensive therapy or completed a rehabilitation programme. However, we have modified the "lifetime ban" penalty in Recommendation 24 to allow for the possibility that, after automatic revoca-

"I don't believe we have any effective rehabilitation system set up. There is no way to predict who is treatable and who is not."

Dr. Nanette Gattrell, Associate Clinical Professor, University of California, San Francisco, quoted in the Globe and Mail, July 25, 1991

tion of his licence for a mandatory minimum of five years, if there is no probability of abusing patients or others in the future, a doctor may apply for reinstatement of his licence.

The Task Force is convinced that the College, in order to meet its statutory obligation to the public, must require evidence of a clear rehabilitation plan with clear goals, then evidence that the plan has been followed by the doctor, then evidence of positive outcomes, and then evidence of a clear plan for reinstatement with practice limitations where appropriate.

Changes in the Complaints and Discipline Process

Within the past year, the College has made a number of changes in the way it handles complaints of sexual abuse, including interviewing complainants as a matter of course and putting such complaints on a "fast track". We are recommending a number of additional changes to the complaints and discipline process.

There are a number of obstacles to reporting of physician abuse. Among them are the public perception that the procedures involved are intimidating and that the policies and process currently in place at the College are strongly biased in the doctor's favour. With two exceptions, the complainants we met who had experienced part or all of the College process found it to be daunting, demeaning, and retraumatizing. This situation not only furthers the damage already done by the sexual abuse, but prevents the level of reporting the College needs to fulfil its mandate of protecting the public. To self-govern effectively, the College needs to support vulnerable witnesses such as abuse survivors so they can provide the most accurate evidence possible to the Discipline Committee.

Among the changes we are recommending are:

- Increased support for complainants, including assistance in drafting the complaint, counselling, and assistance for those with special communications needs, all at College expense(Recommendations 30 31).

- **Increases** in the number of **female members** and the number of **public members** who sit on the Complaints and Discipline Committees, and that these panels be chaired by a public member, with skill and training in adjudication. Members of these committees are to be selected with demonstrated expertise in understanding sexual abuse as a principal criterion (Recommendation 32).

- Maintaining year round operation of two **discipline panels**, to reduce the delay in cases being heard (Recommendation 37).

- Greater participation by the complainant at the hearing, through the right to participate as an **Intervenor**, thereby entitling her legal representative to review medical records and other documents, cross-examine defence witnesses, and introduce evidence including expert testimony. We are also recommending that she be able to have a

support person present at the hearing if she wishes (Recommendation 38(a)).

- A requirement that lawyers hired by the College to prosecute sexual abuse cases must have demonstrated expertise in the theory and practice of conducting a sexual abuse case, with an appreciation of the impact on the complainant as well as the doctor (Recommendation 41).

- Involvement of the prosecutor immediately on the complaint being referred to Discipline (rather than close to the hearing date) and giving the complainant the right to meet with, and participate in, the selection of the prosecutor from a group of lawyers provided by the College (Recommendation 40).

- A requirement that any decision not to refer a complaint to the Discipline Committee must be supported with a full explanation in plain language given to the complainant, with a **genuine** opportunity to ask questions and receive answers about the decision (Recommendation 36).

Changes Outside the College: Law and Policy Reform

Most of the crucial "first steps" in improving response to the issue of sexual abuse of patients can be taken by the College using its own power and resources. However, fundamental change is an incremental process accelerated when laws and government policies are changed to reflect the shift in society's values.

Sanctions against sexual abuse involving breach of trust by health professionals must be made more effective.

Based on our legal research, Recommendation 19 has been changed to protect doctors from malicious or vexatious reporting. Recommendation 54 has also been modified to propose further exploration of the use of allowing an expert to testify at a discipline hearing rather than requiring vulnerable witnesses suffering from post-traumatic stress disorders to testify. The legal foundation for our recommendations is examined extensively in the Legal Appendix.

Valuing the Contribution and Expertise of Public Members

We are recommending that Government compensate public members on the governing Council of the College with a per diem the same as that paid to doctor members. The work required of public members is the same as that required of doctor members, and the perspective of public interest and safety they bring to decisions is important. Complaints and Discipline Committees cannot function without their public members. The work is demanding and time consuming, yet public members receive only 20% of what doctors receive.

Preventing Re-victimization of Abused Patients

We believe that patients and the witnesses who support them in a hearing have a right to privacy. We endorse the amendments to the **Health Disciplines Act** proposed in the **Regulated Health Professions Act** (RHPA). Under the RHPA Procedural Code, upon request, regardless of whether the hearing is open or closed to the public, names and identifying facts about the patient and supporting witnesses must not be revealed. The Task Force is also recommending that both Sections 44 and 45 of the proposed Procedural Code provide for sanctions when privacy orders are violated.

We are convinced that a time limitation on the right of a patient to bring a complaint to the College or to sue a doctor for damages due to sexual abuse (two different and separate legal procedures) is not just. Given the reality that delays in reporting sexual abuse are characteristic of the damage it causes, and that survivors need time before being able to come forward, we are recommending that there be **no limitation period on sexual assault** occurring in or as a result of a relationship of authority, trust, or dependency (Recommendation 57).

Children and adults who have been sexually abused by someone in a position of authority are especially vulnerable to further victimization. We have made a number of recommendations on changes to the College process, but there will continue to be complainants whose trauma from the abuse will be dangerously exacerbated by even an improved process. Therefore, the **Ontario Evidence Act** needs to be amended to allow evidence from such traumatized victims to be presented in trustworthy manner (by third party expert, by monitored video) which does not require the victim to be present at the hearing (Recommendation 54).

A sense of powerlessness over what is going on at a hearing increases the damage already done by sexual abuse. We have recently been made aware of discussions between the College and defence counsel about a possible new practice direction for cases before the Discipline Committee. We are very concerned that there continues to be significant under-appreciation of the damage done to patients because only the College (which is the only "representative" of the patient at the present time) is currently required to disclose its evidence and arguments in advance of the hearing, with no requirement by the defence counsel for the doctor to do so. This practice has sometimes led to the College prosecutor being unable to prosecute effectively. We are therefore recommending that:

step 1: the College must modify now its rules of practice to require the fullest possible disclosure using as models the Ontario Pay Equity Tribunal and the Ontario Human Rights Commission; and,

step 2: the **Health Disciplines Act** (or the proposed **Regulated Health Professions Act**, 1991) be amended to create a statutory obligation on all parties for disclosure prior to the hearing (Recommendations 43, 49).

Greater Accountability of Hospitals to Patients at Risk

Testimony to the Task Force has revealed troubling practices by hospital management (executives and Boards) in some hospitals in Metropolitan Toronto, Ottawa, Sarnia and North Bay. The situations are current and the information we have received convinced us that the **Public Hospitals Act** and other acts need to be amended to create a clear, positive obligation on hospital administrators:

- To initiate and maintain education about the actual damage done by sexual abusers in hospitals and the risk of harm to patients created when hospital staff do not report sexual abuse.

- To publicly report on safeguards implemented and the disposition of complaints received.

- To report to the College the names of doctors complained against.

Financial Compensation to Abused Patients - A New Fund

We are recommending the creation of a **Survivors Compensation Fund** to pay out-of-pocket expenses to survivors so they can get the therapy needed to recover. At the moment, abused patients must shoulder the burdens of:

- Trying to find an appropriate therapist while traumatized by a doctor's abuse.

- Having to pay out of their own pockets ($50 - $100/hour is common) if they are fortunate enough to find appropriate help, since few caregivers who can bill OHIP have appropriate training in the specialized therapy required.

- Spending a significant length of time in therapy dealing with the results of the physician's abuse as well as finding appropriate care for their original health problem.

The Task Force noted with profound concern that the taxpayer-funded Ontario Health Insurance Plan (OHIP) allows an abusing doctor - because he billed OHIP for his "services" while the abuse occurred - to profit financially from abuse.

The fund would use as sources of revenue:

1) proceeds from a doctor found guilty of sexual abuse or sexual impropriety, including

    a) the fines imposed by the Discipline Committee on a finding of guilt; in addition to,

b) the doctor paying into the Fund the amounts paid to the doctor by OHIP when sexual abuse, rather than medical treatment, was occurring; as well as,

2) proceeds from a levy, (similar to the Lawyers Fund for Client Compensation which has current assets of approximately $32 Million) to which all members of the Ontario Medical Association (OMA), contribute. The Task Force suggests that 1% of the annual membership fee paid to the OMA could be an initial contribution from the medical profession as a clear demonstration of its collective responsibility to patients who have been harmed by a member of the profession (Recommendation 56).

Conclusion: Honouring the Public Trust

The Task Force was asked to gather information about the extent and seriousness of sexual abuse of patients by doctors. The evidence presents very disturbing images and so we are proposing recommendations with a vision of a changed future.



Task Force members Roz Roach and Marilou McPhedran at one of the public hearings

The Task Force notes the logic of the many groups and individuals who observed that the College operates as an "old boys' club" and urged that the Government of Ontario remove self-regulation. However, the College has clearly committed itself to considering significant changes and has invested substantial resources to examining the changes recommended by this Task Force. For this reason, the Task Force has made Recommendation 1(b)(c), which would ensure an effective monitoring and evaluation process to determine whether self-regulation of the medical profession can actually achieve the standard of **Zero Tolerance** of sexual abuse of patients. It will be up to the Minister of Health through the process she has already begun, to determine whether the public interest is being adequately served by the College in this regard.

By 1994, if the recommendations are substantially implemented by the College and the Ministry of Health, it will be possible to demonstrate the philosophy of **Zero Tolerance** in action. Meeting the standard of **Zero Tolerance** will benefit patients and doctors through effective self-regulation and thereby honour the public trust.

References

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MAJOR CHANGES IN RECOMMENDATIONS FROM THE PRELIMINARY TO THE FINAL REPORT

RECOMMENDATION # FROM PRELIMINARY REPORT	PRELIMINARY REPORT	FINAL REPORT
Recommendation 1	Preliminary Report called for College to adopt philosophy of Zero Tolerance.	Final Report eliminates this recommendation as it has already been adopted unanimously by the College Council (May 27, 1991).
Recommendation 7	Preliminary Report called for Patients' Bill of Rights, mandated poster of Bill of Rights to be placed on wall of every location where physicians practise. Removal of Bill of Rights by a physician to be penalized by College.	Final Report renames document "The Physician's Commitment to Patients" statement, and includes the Task Force proposal for this statement in Chapter 3. Recommends College support and encourage the display of a poster containing this statement in every location where physicians practise.
Recommendation 10, 11	Preliminary Report recommended doctors abide by requirements set out for sexual contact with former patients.	Final Report changes these requirements to guidelines for professional misconduct for physicians to be issued by the College to all its members.
Recommendation 12	Preliminary Report recommends Patient Relations Committee to respond to doctors' questions about guidelines in Recommendations 10 and 11.	Final Report recommends Guidelines Committee to review models from other jurisdictions to determine if guidelines are sufficient or if statutory changes are needed.

RECOMMENDATION # FROM PRELIMINARY REPORT	PRELIMINARY REPORT	FINAL REPORT
Recommendation 13	Preliminary Report recommends evaluation team review College's activities in implementing change in annual reports to Minister of Health followed by an evaluation of self-regulation in 1994.	Final Report endorses Minister's intention to establish a Monitoring Board and urges Minister of Health to proceed immediately to monitor the implementation of Task Force recommendations in annual reports followed by (Recommendation 1 (b)(c)) one evaluation report to Minister in 1994 based on more specific criteria.
Recommendation 14	Implementation Committee at the College.	Becomes Recommendation 1(a) in Final Report to proceed with changing practices and policies at the College to meet the standard of zero tolerance.
Recommendation 17	Exemption from reporting physician abuser for treating physician, if the abuser is in treatment and has limited their practice.	Exemption removed. Report to College can cite fact physician is in treatment.
Recommendation 19	Preliminary Report -- all those reporting sexual impropriety or abuse should be immune from civil liability.	Final Report -- reports of sexual impropriety or violation must be in good faith and on reasonable grounds to invoke immunity from civil liability.
Recommendation 20	Preliminary Report recommendation to apply reporting requirements to all health disciplines has been removed because RHPA will establish review of sexual abuse in all regulated health professionals	Final Report has new recommendation 20 which recommends College change its licence application to include information re: good character, similar to the Law Society.

RECOMMENDATION # FROM PRELIMINARY REPORT	PRELIMINARY REPORT	FINAL REPORT
Recommendation 24	Preliminary Report called for two categories of abuse: impropriety and abuse, with abuse conviction requiring penalty of permanent revocation of licence - no exceptions.	Final Report calls for two categories of abuse: sexual impropriety and sexual violation, with conviction for sexual violation requiring penalty of revocation for a minimum of five years, with stringent criteria for reinstatement to practice of medicine.
Recommendation 25	Preliminary Report recommendation absorbed into recommendation 24 in Final Report.	Final Report creates new Recommendation 25 which calls for changes to ensure privacy of patient/complainants in College activities.
Recommendation 27	Preliminary Report required staff training dealing with sexual abuse.	Final Report adds Recommendation 27(a), requiring College to develop hiring criteria and performance standards for staff dealing with sexual abuse.
Recommendation 32	Increasing number of women and public members on Complaints and Discipline Committees.	Expanded in Final Report.
Recommendation 39	Preliminary Report recommended complainant be able to put hold on process at College at any time.	Final Report recommends complainant be granted a reasonable adjournment of process if requested up to the time when the case is referred to the Discipline Committee.

RECOMMENDATION # FROM PRELIMINARY REPORT	PRELIMINARY REPORT	FINAL REPORT
Recommendation 47	Preliminary Report recommended required training for doctors involved in psychotherapy.	Final Report recommends creation of Medical Psychotherapy Joint-Committee to examine this issue in depth.
Recommendation 52	Not in Preliminary Report.	Final Report recommends legal changes to allow Discipline Committee to consider together evidence from more than one complaint; and to reach a decision without corroboration in abuse cases.
Recommendation 54	Preliminary Report suggested that third party experts be able to give a child's evidence in a hearing.	Final Report amends relevant acts to allow statements of children and vulnerable adults into evidence, and to allow use of other devices to protect those who testify; also suggest code of ethics for cross-examination of children and vulnerable adults.

LIST OF RECOMMENDATIONS

Recommendation 1

a) That the College immediately establish an **Implementation Committee** to implement all of the recommendations approved by the Council of the College. That the **Implementation Committee** consist of representatives drawn from College Council and staff at all levels, and, in recognition of their demonstrated expertise, at least three representatives of the Task Force and/or the Advisory Council who are not members of the College Council. We suggest that a senior member of the College be clearly charged with the responsibility of chairing the Implementation Committee and presenting a detailed annual progress report to the public, the Minister of Health, and the College Council at its Annual General Meeting in 1992, 1993, and 1994.

b) That the Minister of Health go beyond studying the issue of sexual abuse of patients and **reinstate** her proposal to add to the **Regulated Health Professions Code** a **Patient Relations Monitoring Board** or its equivalent to evaluate implementation by the College of Physicians and Surgeons of Ontario (and soon, other Colleges), so that the Government of Ontario continues to provide effective leadership to bring about solutions to the problem of sexual abuse of patients.

That the Minister of Health, should she decide to exclude the **Patient Relations Monitoring Board** from the **Regulated Health Professions Act**, nevertheless take immediate steps to appoint an **Evaluation Team** to monitor and report annually on the implementation of the recommendations of this Task Force, rather than wait until all the other Colleges in the **Regulated Health Professions Act** have "caught up" to the initiatives of the College of Physicians and Surgeons of Ontario.

c) That the **Evaluation Team** or its equivalent present an evaluation of the College's progress to the Minister of Health and to the Annual General Meeting of the College in 1994 that contains a recommendation as to the appropriateness of continued **self-regulation** in investigating members accused of sexual abuse of patients. That the evaluation be based, **at minimum**, on:

i) the use of well-publicized public hearings to gather information;
ii) a test of the system by professionals with expertise in sexual abuse, to check that complainants and physicians feel they are being heard, and that complainants and physicians are being treated appropriately;
iii) a review of any reinstatements granted to physicians whose licences have been revoked or suspended for sexual abuse;
iv) whether there has been an increase in the number of sexual abuse complaints received and processed by the College, and
v) the outcome of those complaints.

The Task Force believes that compliance with the philosophy of **Zero Tolerance** must be tested. One important test will be that there are no reinstatements of licences to physicians found guilty by the College of sexual abuse, unless all of the criteria for reinstatement specified in Recommendation 24 have been met.

That, should the recommendation in May 1994 be for continued self-regulation, that the Evaluation Team or its equivalent remain in place to continue to monitor and assess compliance, making an evaluation and public report to the Minister and the College every three years.

Recommendation 2

That the College initiate changes in medical training at all levels, including undergraduates, interns, residents, fellows, faculty, practising physicians, and foreign medical graduates to increase the time and content devoted to curriculum on sexual abuse, **and** that this training be included in examinations and accreditation throughout training and practice.

That the curriculum developed must reflect an understanding of the context in which sexual abuse and sexual abuse by physicians occurs, including: gender socialization, sex roles, women's equality issues, cultural variables, and the position of power the doctor brings to the doctor-patient relationship. It must also encourage development of healthy feelings, values, and self-awareness about sexuality. At minimum, the following subjects must be covered:

Improved Treatment for Sexual Abuse Survivors

- Knowledge of the magnitude of the problem of sexual abuse and sexual abuse by physicians, the consequences to victims, and issues of race, gender and class related to abuse.

- The range of problems with which victims of sexual abuse and sexual abuse by physicians present.

- Barriers to disclosure and how to facilitate disclosure.

- Management and treatment options including the need for specialized training to treat sexual abuse survivors effectively.

- The importance of checking for sexual abuse when history-taking, when this is appropriate, and how to do it appropriately.

- Strategies for recognizing, confronting, and treating abuse by colleagues and how to report knowledge or suspicion of abuse by colleagues.

- How to sensitively recognize and treat patients who, because of past sexual abuse or trauma, might perceive their physician's genuine concern as alarming and a threat to their integrity, and how to handle this appropriately.

- The recognition and appropriate care of victims of female circumcision.

Improved Understanding of Appropriate Interactions and Behaviours

- How to set and enforce appropriate treatment boundaries for oneself and the patient.

- How to discuss sexuality and sexual issues and how to perform examinations in an acceptable, non-abusive manner.

- How to give care and comfort, including touching, in an appropriate non-sexual manner.

- How to get help for oneself before abusing, including how to recognize signs in one's own behaviour that indicate that sexual abuse of a patient may occur.

Recommendation 3

That the College move swiftly to ensure that practising physicians also know:

- That, due to the power the physician brings to the physician-patient relationship, there is no such thing as gaining consent for sexual involvement with a patient.

- The warning signs of behaviour that indicate that sexual involvement with patients may occur, and what to do to prevent abusing.

- That a physician has a right to refuse to examine any area of the body of a patient or to terminate the relationship, if the physician feels that the patient is sexualizing the relationship, and how to do this appropriately.

- Where survivors of sexual abuse can find effective treatment.

- The physician's legal obligation to report sexual abuse by another physician (as proposed in Recommendations 15 and 16).

- The nature of the offences of sexual impropriety and sexual violation, as outlined in Recommendation 24.

Recommendation 4

That the College initiate the establishment of a **Joint Education Committee** on sexual abuse to develop and implement the necessary curriculum changes, methods of teaching, and accreditation/ examination processes. Membership on this **Joint Education Committee** must include senior representatives of the following groups and organizations:

a) government, including: the Ministry of Colleges and Universities and the Ministry of Health;

b) the medical community, including: the Ontario Medical Association (OMA), the Council of Faculties of Medicine, the Medical Council of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Psychiatric Association, the Ontario Psychiatric Association, the College of Family Physicians of Canada, the Ontario College of Family Physicians, the Association of Canadian Medical Colleges, the committee planning Education of Future Physicians of Ontario (EFPO), the General Practice Psychotherapy Network and the Ontario Hospital Association; and,

c) front-line advocacy organizations with relevant expertise, including: the Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN), the Metro Action Committee on Violence Against Women and Children (METRAC), the Disabled Women's Network Canada (DAWN Canada), the Ontario Native Women's Association, and the Coalition of Visible Minority and Immigrant Women.

We suggest a sub-committee made up of the College, the Council of Faculties of Medicine, the OMA, the Ministry of Health, the Ontario Psychiatric Association and at least three advocacy groups be clearly charged with the responsibility of implementing the changes.

Progress reports from this Joint Education Committee must be presented to the annual general meeting of each of the membership organizations and to the **Minister of Health** each year for the next three years, beginning in 1992.

Recommendation 5

That the College establish a clear and ongoing liaison with the committee planning Education of Future Physicians of Ontario (EFPO) and the Council of Faculties of Medicine, to help facilitate the required changes in undergraduate medical education.

Recommendation 6

That the College, the Law Society of Upper Canada, and the Metro Action Committee on Violence against Women and Children (METRAC), together with representation from survivor advocacy groups and survivors, cooperate in developing a continuing education program geared to the effective investigation and prosecution of sexual abuse complaints against physicians and other health care providers, including training in appropriate treatment of child witnesses and vulnerable adult witnesses. Only lawyers who have completed this course should be eligible for selection as prosecutors of sexual abuse complaints at the College. (This recommendation is already in the planning stages by the College, the Law Society, and METRAC).

Recommendation 7

That the College, together with the Ontario Medical Association, the Ontario College of Family Physcians, the Ontario Psychiatric Association and survivor and patient advocacy groups such as the Disabled Women's Network Canada, the Patients' Rights Association, and the Metro Action Committee on Violence Against Women and Children (METRAC), and representatives from the Ministries of Health, Education, and Community and Social Services develop an information brochure for patients. That this brochure contain the **Physician's Commitment to Patients**, the indicators of appropriate physical examinations, the list of warning signs and examples of sexually abusive behaviours contained in this Report, the options available for reporting and for help, and how to access the College, including the address, telephone numbers, and who to contact. That this brochure be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape. That the College require this brochure to be available in every location where physicians practise and require that it be provided by members to any patient who discloses sexual abuse by another doctor.

That the **Physician's Commitment to Patients** also be prepared in poster form, and include the right to appropriate medical examinations; the right to say "no;" the right to ask questions, the right to understand, to the best of the patient's ability, what is happening to his or her body during treatment; the right to report sexual abuse by a physician, and how to access the College.

That the College encourage and support in all ways possible the display of the **Physician's Commitment to Patients** poster in every location where physicians practise. That the College also encourage the display of the brochure and the poster at other health and treatment centres, schools, sexual assault care centres, health clubs, community centres, and public centres, and make them available to these centres.

Recommendation 8

That the College actively promote public awareness of its role, policies, and procedures, the **Zero Tolerance** standard, and the entire complaints and discipline process in as many ways as possible, beginning with production of a poster and a brochure. That these be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape for those who are print handicapped. That the College, in cooperation with the **Ontario Hospital Association**, ensure the brochure is available in every location where physicians practise and encourage and reward the display of the poster there. That the College also encourage the display of the poster and brochure in the other locations in Recommendation 7 and make them available to these locations.

Recommendation 9

That the College initiate the establishment of a **Joint Committee on Medical-Psychotherapy** to review and recommend ways to ensure that physicians carrying out full-time or part-time psychotherapy have adequate training, particularly in the care of survivors of sexual abuse. Membership in this committee should include, at minimum, senior representatives of the College, the Ontario Psychiatric Association, the Medical-Psychotherapeutic Institute of Ontario, and the Ontario College of Family Physicians and the General Practice Psychotherapy Network. At minimum, the committee's recommendations need to address two issues:

1. How to ensure that physicians practising psychotherapy are adequately trained to treat sexual abuse survivors effectively, including training in appropriate boundary management.

2. How to prevent physicians who have lost their licences due to a finding of guilt related to sexual abuse from becoming unlicenced psychotherapists, with the potential to abuse patients again.

That the Committee issue preliminary recommendations and an implementation plan to the College and the Evaluation Team proposed in Recommendation 1 by June 1992.

Recommendation 10

That the College issue a guideline, effective immediately, that a physician should not have sexual contact with a former patient for a period of **two years** following the date of the last professional contact with the patient, even if the physician has formally terminated the professional relationship.

Recommendation 11

That the College issue a guideline, effective immediately, that, when the physician-patient relationship has been primarily for the purpose of **psychotherapy**, sexual contact with the patient is prohibited during the professional relationship and at **any time thereafter**, due to the lasting nature of transference and the power imbalance, and hence the potential for abuse created.

Recommendation 12

That in addition to immediately adopting and issuing the guidelines for doctors proposed by this Task Force, the College establish a **Guidelines Committee** to examine models from other jurisdictions and determine whether statutory changes would be more effective. That this committee include representation from the College and the Advisory Council to this Task Force, the Ontario Medical Association (including the Women's Issues Committee), the Ontario Psychiatric Association (including the Women's Issues Section), and at least two representatives of survivor advocacy organizations with demonstrated expertise in the area of physician-patient sexual abuse.

Recommendation 13

That if the information was obtained in the course of a physician-patient relationship where the patient is a physician, and the treating physician is satisfied that the patient has limited or withdrawn from practice to the extent required to eliminate risk of harm to other patients, the report to the College include a notation that the physician is in treatment and has agreed to limit practice appropriately and that the treating physician be required to notify the College when the physician-patient leaves treatment.

Recommendation 14

That the College re-issue its guideline that physicians should make a third party readily available to their patients at all times during internal examinations if the patient so wishes, that it be incumbent on the physician to inform the patient of the option to have a third party present, and that this precaution is essential regardless of physician/patient gender.

Recommendation 15

That the College issue a guideline immediately and that the **Regulated Health Professions Code** be amended so that it is **mandatory** that a member of the College notify the College in writing when he or she has reason to believe that another member of the College is or has been engaged in sexual impropriety or sexual violation, as defined in Recommendation 24, and that such information be recorded and retained by the College. A member who knows the name of the offender, even though the patient has not explicitly named the offender, is obligated to report the offender's name, but not the patient's name, unless the patient specifically so agrees in writing.

Recommendation 16

That the College make it a policy that any person who has knowledge of any sexual impropriety or sexual violation in a physician-patient relationship may report to the College, and the College must record and retain the information in relation to the physician, on a confidential basis, until the Registrar, in accordance with the statutory safeguards, including the approval of the Executive Committee of the College, proceeds with the investigation.

Recommendation 17

That reports by third-parties are to include the physician's name, but not the patient's name, unless the patient specifically so agrees in writing, and not the reporter's name, unless the reporter is a member of the College or unless the reporter agrees to identification.

Recommendation 18

That where there is more than one third-party complaint about a physician, the College's Director of Public Complaints and Investigations be required to bring the physician's file to the attention of the Registrar and the Executive Committee of the College, for a review of the evidence available and a decision on whether an investigation will be initiated.

Recommendation 19

That any person, health care facility, business, or organization be immune from civil liability for submitting a report of sexual impropriety or sexual violation to the College, when submitted in good faith and on reasonable grounds.

Recommendation 20

That the College immediately amend its licence application, guided by the precedent of the **Law Society of Upper Canada**, to include a non-exemptible requirement to answer questions to enable the Registrar and/or the Registration Committee to determine whether or not the applicant is of **good character** sufficient to be allowed to practise medicine in Ontario.

Recommendation 21

That physicians, as a condition of licensure or re-licensure, continue to be obliged to report on an ongoing basis to the College criminal charges against them and disciplinary action against them by other Colleges or professional bodies and be obliged to report civil suits initiated against them where the charges allege sexual abuse, and that the College check previous licensing bodies for such charges prior to granting a licence.

Recommendation 22

That the **Solicitor General of Ontario** be asked to initiate mandatory reporting to the Colleges listed in Schedule 1 of the **Regulated Health Professions Act** (RHPA) of any charge laid against an Ontario physician or other member of a Schedule 1 profession, as soon as the charge is laid.

Recommendation 23

That where the College has made a finding of guilt of sexual impropriety or sexual violation, it immediately inform other provincial Colleges of Physicians and other related bodies in Canada and the United States, specifically the **Board Action Data Bank** kept by the Federation of State Medical Licensing Boards in Fort Worth, Texas, and that a protocol for mutual reporting be developed by the College with the **Federation of Medical Licensing Authorities of Canada.**

Recommendation 24

That the **Regulated Health Professions Act** be amended to include **two levels** of the offence of sexual abuse of patients:

I Sexual Impropriety, and
II Sexual Violation

As defined in this Recommendation,

I. Sexual Impropriety will comprise any behaviour, gestures, or expressions that are seductive or sexually-demeaning to a patient; inappropriate procedures, including, but not limited to, inappropriate disrobing or draping practices that reflect a lack of respect for the patient's privacy or deliberately watching a patient dress or undress instead of providing privacy for disrobing; subjecting a patient to an examination in the presence of medical students or other parties without the explicit written consent of the patient or when consent has been withdrawn; examination or touching of genitals without gloves; inappropriate comments about or to the patient, including, but not limited to, making sexual comments about a patient's body or underclothing; making sexualized or sexually-demeaning comments to a patient; criticism of the patient's sexual orientation (homosexual or heterosexual or bisexual); making comments about potential sexual perfomance during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction; requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation; making a request to date; initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician; and kissing of a sexual nature.

The penalty range for Sexual Impropriety would include reprimand, apology, fine, temporary suspension of licence, with conditions, or any combination thereof.

II. Sexual Violation will include physician-patient sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may be reasonably interpreted as sexual, including, but not limited to, sexual intercourse, genital to genital contact, oral to genital contact, oral to anal contact, oral to oral contact except Cardiopulmonary Resuscitation, touching breasts or genitals except for the purpose of appropriate physical examination or treatment or where the patient has refused or withdrawn consent, and encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present.

The penalty for Sexual Violation would be a mandatory revocation of licence for a minimum of five years and a fine up to $20,000.00.

That the **Regulated Health Professions Code** should be amended to include the fine and mandatory revocation of licence for five years for members found guilty of Sexual Violation. Once the mandatory five year

revocation had been served, the physician would be entitled to apply to the Discipline Committee for reinstatement of his or her licence to practise medicine. The **Regulated Health Professions Code** should be amended so that upon application for reinstatement, the Discipline Committee, the Council or the Executive Committee must require the applicant to fulfill specific requirements including (see Appendix A for a detailed draft amendment):

- Having the College publish a notice of application which informs all physicians of the intention of the applicant to apply for readmission, and outlines how to contact the College with any relevant information prior to the applicant's readmission hearing.

- Providing a written brief demonstrating the ways in which readmission would be in the public interest.

- Making good all financial losses caused by his or her sexual abuse.

- Filing a statutory declaration setting out in full his or her business or employment activities during the period following revocation of his or her licence.

- Filing a certificate from his or her treating professional detailing the course of treatment entered into and stating the treating professional's opinion of the applicant's compliance with treatment goals and the success of treatment overall.

- Filing a certificate from an independent assessor who has evaluated the course of treatment and formed an opinion as to its success in ensuring that the applicant poses no danger to future patients.

- Filing a series of documents prepared by the treating professional and the assessor, including an assessment of how the abuse occurred, an outline of specific rehabilitation goals and whether or not they have been met and a list of specific changes in behaviour which have occurred through the rehabilitation process.

- Filing a re-entry plan developed by the independent assessor, which includes substantive safeguards to prevent further sexual impropriety or violation.

- Demonstrating a commitment to ongoing rehabilitation therapy, including submitting quarterly reports to the College on the status of his or her recovery.

In hearing an application for reinstatement, the Discipline Committee would be required to carefully consider each of the aforementioned documents, as well as:

Recommendation 24 (cont'd)

- Testimony from the applicant, the treating professional and the independent assessor as to the applicant's understanding of the harm done by his or her abuse and the effectiveness of rehabilitation in this case, the specific changes in behaviour which have taken place, the commitment to ongoing rehabilitation and specific rehabilitation goals, the proposed safeguards in place should the physician be reinstated, and any practice restrictions including monitoring which are recommended.

Having reviewed all evidence regarding the rehabilitation of the applicant, the Discipline Committee must be convinced that:

- The evidence presented, including expert evidence, satisfies to a substantial degree of medical and psychological certainty that the applicant will not abuse patients or other vulnerable persons in future.

- Readmission would be in the public interest
(see Appendix B for draft amendment specifying reinstatement criteria).

Recommendation 25

That the privacy of patient/complainants be better protected by the College, given the exceptions to secrecy proposed in Section 31 of the **Regulated Health Professions Act**, by:

1) Immediately beginning to delete the name of patient/complainants from documents accessible to College staff or lawyers and their staff.

2) Omitting graphic intimate details which may identify the patient including personal information unrelated to the facts of the physician abuse in the Report of the Discipline Committee which is public and widely distributed.

Recommendation 26

That the College identify in Regulations to the Act examples of sexually abusive behaviours in the two-tiered offence and ensure that these behaviours are known and understood by the physicians of Ontario.

Behaviours considered Sexual Impropriety or Sexual Violation (see Recommendation 24) include, (the occurrence of, or attempt to, or inducement to) but are not limited to:

- Watching a patient dress or undress, instead of providing privacy for disrobing.
- Deliberately making sexual comments about a patient's body or underclothing.
- Making sexualized or sexually-demeaning comments to a patient.
- Criticism of the patient's sexual orientation.
- Making comments about potential sexual performance during a

examination or consultation, except clinical comments where the patient's purpose in seeking the consultation was to discuss sexual issues.
- Making a request to date.
- Subjecting a patient to an examination in the presence of medical students or other parties without the explicit consent of the patient.
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation or presenting problem.
- Initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physician.
- All contact with genitals without the use of gloves

Recommendation 27

a) That the College, together with the Metro Action Committee on Violence Against Women and Children (METRAC) develop hiring criteria and performance standards for staff who will be involved with individuals contacting the College about sexual abuse.

b) That immediate, substantive and ongoing training be provided to all College staff who may, in any way, have contact with an individual inquiring or complaining about sexual abuse, (including receptionist, secretary, investigator, inspector, patient representative, and manager) as well as every member of Council, especially those sitting on, or likely to sit on, the Complaints or Discipline Committee within the next two years. That this training must address the common tendency to blame the victim and must include at minimum:

- The nature of sexual abuse by physicians, the magnitude of the problem, the consequences to victims, and issues of race, gender, and class related to abuse.

- The range of ways a survivor may initiate disclosure or inquiry, and how to facilitate and handle disclosure, inquiries, complaints, and information dissemination in an appropriate, empathetic, and supportive manner.

- How to fully and appropriately explain the complaints and discipline process of the College to potential complainants.

- The options a complainant has to lodge a complaint of sexual abuse through the criminal and civil justice systems.

- How to address survivors and those making inquiries with sensitivity and respect (for example, not addressing or referring to an adult woman as "girl").

- The characteristics of Sexual Impropriety and Sexual Violation, as outlined in Recommendation 24.

Changes in the Investigation and Complaints Process

Recommendation 28

That the College make it a policy that the entire complaints and discipline procedure up to and including final decision and options to appeal, be explained in full to a complainant before he or she is asked to make a written complaint, including the steps in the process, the disposition of medical records, the options available, the requirements of the complainant, the possible outcomes, and the resources the College will make available to him or her.

Recommendation 29

That there be very **frequent, clearly-worded communications** on the progress of the investigation, complaint, and discipline process between the College and the complainant and between the College and the physician and that care be taken that any communication from the College to complainants and physicians or their representatives be respectful and not attempt to intimidate or obstruct access to justice. That the College check with the complainant or physician to ensure that such communication has been understood.

Recommendation 30

That the College make it a policy to offer to complainants assistance in writing a complaint, including the assistance of a sensitive, trained investigator or patient representative, as well as provide whatever assistance is necessary to those complainants with **special communications needs,** such as language interpretation, cultural interpretation, or sign language interpretation and the ability to make the complaint on tape, if needed. That these resources be made available at College expense.

Recommendation 31

That the **College** make it a policy to offer to complainants support and/or counselling from outside the College throughout the complaints and discipline process if he or she does not have any, and so wishes, including **support, counselling, advocacy**, and whatever assistance is necessary for complainants with special communications needs, and continue to cover the costs of transportation, accommodation, and child care expenses. That these resources be made available at College expense.

Recommendation 32

That the **College** retain expert advice to develop an action plan on how to effectively encourage **women doctors** to serve on the Council and that the College encourage the **Minister of Health** to facilitate further appointments of women, including **women who are members of racial minorities or who are disabled, as public members**.

- That the College immediately increase the number of women and public members who sit on the Complaints and Discipline Committees; that the Complaints Committee and each panel of the Discipline Committee be composed of at least two women and the maximum possible number of public members; and that these panels be chaired by a member, not necessarily a doctor, with skill and training in adjudication of administrative tribunals.

- All members of the Complaints and Discipline panels are to be selected for their **demonstrated understanding and expertise** in sexual abuse as one principal criterion, in addition to being open-minded and knowledgeable in other areas deemed by the College as relevant to its obligations in regulating the profession.

- Before sitting on any of these panels, all members must have completed the **training program** being jointly developed with the Law Society of Upper Canada and METRAC (Recommendation 6) as well as the College's own internal training program, once these programs are available.

Recommendation 33

That the College continue its policy that when the Complaints Committee is satisfied that there is enough evidence of sexual abuse "on the face of the file" (prima facie), the complaint should always be referred to the Discipline Committee.

Recommendation 34

That in sexual abuse complaints, the College begin immediately, as standard procedure, to exercise its existing **statutory authority to seize** the patient's medical records and any other relevant materials, with a search warrant if required, at the beginning of the investigation process, without prior notice to the physician.

Recommendation 35

That the College use the revised confidentiality sections of the **Regulated Health Professions Act** (Section 32(1)(b)) to commence a specific investigation when the Registrar determines whether other patients of the physician might be able to provide evidence related to the complaint by carefully reviewing the doctors' medical records for indications that other patients may be victims while ensuring that confidentiality of their medical records is protected. Each patient so contacted to receive a copy of the decision of the Complaints or Discipline Committee within six weeks of that decision.

Changes in the Discipline Process

Recommendation 36

That the College continue its policy that any decision not to refer a sexual abuse complaint to the Discipline Committee must be supported with a **full explanation in plain language** given to the complainant, and make it a policy that there be a genuine opportunity for the complainant to ask questions and receive answers about the decision. At the same time, the complainant must be fully informed of the appeal procedure to the Health Disciplines Board and that this process is separate from the College.

Recommendation 37

That, in order to help reduce the delay in hearing sexual abuse cases, the College actively recruit the public members needed to increase the number of Discipline panels to two, until such time as the **Regulated Health Professions Act** is amended to allow for more panels.

Recommendation 38

a) That the College make it a **policy** that the patient/complainant has **guaranteed Intervenor status** in the hearing and the option to have a support person as well as her legal representative present throughout the hearing. Should the patient's **competence as a witness** become an issue at the hearing, the patient should have the right to participate as a **party.**

b) That the **Regulated Health Professions Code** be expanded to give the Complaints and Discipline Committees the same discretion to specify parties as is currently held by the Fitness to Practise Committee.

c) That the **Regulated Health Professions Code** be amended to give explicit authority to the Discipline Committee to use its discretion in allowing **public interest intervenors,** who are not representing the individual or complainant but can bring important perspectives to the deliberations.

Recommendation 39

That the College make it a policy that, until the case is referred to the Discipline Committee, a complainant should be granted a reasonable **adjournment** - if she or he is feeling unable to continue.

Recommendation 40

That the College make it a policy that a prosecutor become involved in a case immediately upon a complaint being referred to Discipline, and that the complainant has a right to meet with the prosecutor, and participate in the **selection of this prosecutor** from a group of lawyers provided by the College.

Recommendation 41

That the College require that lawyers who prosecute sexual abuse cases for the College must have demonstrated expertise in the theory and practice of conducting a sexual abuse case and an appreciation of the impact on the complainant as well as on the physician. Once Recommendation 6 is implemented, that the College only allow lawyers who have completed the **program on sexual abuse** to act as prosecutors.

Recommendation 42

That the College make it a policy that the letter of complaint that goes to the doctor for response is not sent without the **complainant's explicit knowledge and consent.**

Recommendation 43

That the College immediately modify its current practice and require a pre-hearing procedure similar to that employed by the Ontario Pay Equity Tribunal and the Ontario Human Rights Commission, and to ensure the **fullest possible disclosure** of information from all parties prior to a hearing be required immediately.

Recommendation 44

That, when the defence puts forward good character evidence, the prosecution lead expert opinion that **evidence of good character** in professional and community life does not have any bearing on the **propensity** to sexually abuse.

Recommendation 45

That in all cases of sexual abuse, it should be argued by the College that the physician is incompetent due to his "disregard of the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice" as in Section 50(1) of the **Regulated Health Professions Code.**

Recommendation 46

That, to the greatest extent possible, all prosecutions for sexual abuse must present as part of the case before the Discipline Committee evidence related to **actual harm** to the abused patient, **risk of harm** to other patients, the high probability of recidivism, and the current inability of rehabilitation programmes to determine prospectively that a particular abuser will not abuse again.

Recommendation 47

That the College hire an abuse survivor to assist the College in initiating the development of counselling resources for survivors of sexual abuse by physicians, including a **network of survivors** whom a potential complainant could consult with about the experience of pursuing a complaint before deciding to proceed.

Recommendation 48

That the College employ objective outside testing, on a regular basis, to ensure there is sufficient capacity to its **toll-free telephone line** to be accessible (i.e., not constantly busy) to a member of the public and that the College install a **TDD line** to meet the needs of hearing-impaired members of the public.

Recommendation 49

That there be statutory amendments to the **Regulated Health Professions Act** to override the **Statutory Powers Procedures Act** so that the current entitlement of the accused to reasonable information of any allegations should be matched with a requirement on the part of the defence to disclose evidence to be presented.

Recommendation 50

That the section of the proposed **Regulated Health Professions Act** which actually lengthens the time for investigating and presenting a complaint to the Complaints Committee from 60 days to 120 days, be amended to reduce the allowable delay.

Recommendation 51

That the Minister of Health and the Cabinet address the disadvantage created by two-tiered compensation of membership on College Councils under the **Regulated Health Professions Act** by immediately increasing the per diem of public members to the same amount received by College members, to be reviewed annually.

Recommendation 52

That the **Regulated Health Professions Act** be amended as follows:

a) To provide that the College can prosecute more than one sexual abuse case together and that Discipline panels may consider together the evidence from more than one complaint.

b) To authorize the Discipline panels to reach decisions without requiring corroboration in sexual abuse cases.

Recommendation 53

That the **Public Hospitals Act**, the **Mental Hospitals Act** and the **Private Hospitals Act** be amended to include a **positive obligation** on hospital administration to:

a) Include in the hospital's annual report (to be forwarded within one month of its release, to the Monitoring Board in Recommendation 1 or its equivalent to be established by the Minister of Health) specific

information on safeguards against sexual abuse of patients or staff including a thorough background check before hiring or giving admitting privileges, as well as practices, policies and procedures to prevent sexual abuse, and disposition of any complaints received including the disposition time of complaints about sexual abuse by hospital staff or patients.

b) Maintain the highest possible level of education for themselves and other hospital staff as to the actual damage done by sexual abuse including the likelihood that other patients and sometimes staff are placed at risk when an abuser is not reported and suspended;

c) Report to the College the names of all doctors against whom any complaint of sexual abuse has been brought by patients, members of the public, or staff.

That sanctions against inaction on the part of hospital administrators be developed, including that failure to comply with these obligations be subject to a fine of $5,000.00 to be paid to the Survivors Compensation Fund or its equivalent.

Recommendation 54

That the **Ontario Evidence Act** and the **Regulated Health Professions Act** be amended to create exceptions to the "hearsay rule" to allow statements of **children and vulnerable adults** into evidence, and to use expert witnesses to explain the impact of sexual abuse, utilise devices such as screens, 1-way mirrors and closed-circuit television, to protect those who testify; and the adoption of a code of ethics respecting examination and cross-examination of child and vulnerable adult witnesses.

Recommendation 55

That the **Regulated Health Professions Code** be amended to extend the **privacy protections** to include patient/complainants or witnesses in sexual abuse cases.

Recommendation 56

That the **Minister of Health** and the **Treasurer of Ontario** establish a **Survivors Compensation Fund** to receive all monies paid as fines for sexual impropriety or sexual violation. In addition, the doctor must pay into the new Fund the equivalent amount for fees paid by OHIP as "services" when, in fact, the doctor was sexually abusing the patient. As well, proceeds from a levy of 1% of the annual membership fee of the **Ontario Medical Association** (OMA) should be forwarded to the Fund as a clear demonstration by the medical profession of its collective responsibility to patients who have been harmed by a member of the profession. That the procedure for this remedy be established in consultation with the Women's Health Bureau of the Ministry of Health.

Recommendation 57

That the **Limitations Act** be amended immediately in keeping with the March 1991 Report of the Limitations Act Consultation Group so that there will be no limitation period whatsoever on sexual assaults occurring in or as a result of a relationship of authority, trust or dependency.

Recommendation 58

That the Professional Relations Branch of the Ministry of Health immediately provide to members of the **Health Professions Board** substantive training in understanding sexual abuse, similar to that described in Recommendation 27.

Recommendation 59

That the **Director, Public Appointments and Cabinet** immediately include demonstrated understanding of sexual abuse as an important criterion in the selection of people to sit on the Health Professions Board.

Recommendation 60

That the offence of "aggravated sexual assault" in the **Criminal Code** be amended to include "by a person in a position of trust or authority."

KEY DATES

Task Force Announced	January 28, 1991
Meeting With Advisory Council	February 12
First Public Hearing, Toronto	February 19
Meeting With Advisory Council	March 6
Public Hearing, Thunder Bay	March 16 & 17
Public Hearing, Ottawa	March 19 & 20
Public Hearing, Windsor	March 24 & 25
Joint Task Force/Advisory Council/ CPSO Council Workshop	March 27
Public Hearing, Toronto	April 2
Public Hearing, North Bay	April 7 & 8
Legal Round-Table	April 14
Last Public Hearing, Toronto	April 16
Meeting With Advisory Council	April 17
Last Private Hearings	April 22
Cut-off For Input To Preliminary Report	April 24
Meeting With Advisory Council To Review Preliminary Report	May 8
Consultation With CPSO Council And Others	May 8 to May 26
Preliminary Report Issued	May 27
Round Tables On Education, Changes Inside College, Law And Policy Reform	June 18 & 19
Public Hearing To Receive Commentary On The Preliminary Report	June 20

Cut-off For Input To Final Report	July 26
Meeting With Advisory Council To Review Final Report	August 14
Final Report Issued	November 25

HOW TO CONTACT THE COLLEGE

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BY TELEPHONE;

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TOLL FREE:

(800)268-7096

Dr. Michael Dixon, Registrar
Dr. George Morrison, CPSO Council President
Mrs. Linda Franklin, Director of Communications

Chapter 1:

VOICES (a sampling of telephone reports of abuse)



Actual drawing by a survivor of sexual abuse.

VOICES: A SAMPLING OF TELEPHONE REPORTS OF ABUSE*

"It is the first time I have spoken to anyone about this."
"The pain never went away."

Summary: Reports of Abuse by Source
303 reports of sexual abuse
203 from phone calls, 61 from public and private hearings,
39 from letters

To understand this volume of response in a 6-month period, it is worth comparing it to information-gathering elsewhere. Even before the Task Force was established, early in 1991, the College itself had received a significant number - 150 - of reports about physicians sexually abusing their patients during the previous 4 years (1987-1990).

Very few jurisdictions in North America have opened this issue to the public. In November 1984, the Minnesota Task Force on Sexual Exploitation by Counsellors and Psychotherapists held one public hearing after publicizing it through press releases and a mailing to 2000 organizations, agencies and individuals. This resulted in 40 people testifying about abuse by therapists. Following this hearing, the Minnesota Task Force received more than 100 calls and letters. (Sanderson, 1985). During the latter part of 1986 and early 1987, the California Senate Task Force on Psychotherapists and Patients Sexual Relations was contacted by approximately 60 individuals although the Task Force estimated that between 600 and 1700 consumers in California had been sexually exploited by their therapists. (California Task Force Report, 1987). From 1988 to date, the ongoing Task Force in Massachusetts has documented almost 200 cases and has yet to release its Final Report (McCarthy, Communication to the Task Force, 1991)So our Task Force sample of 303 reports, including 61 involving direct testimony or face-to-face meetings may well be the largest sampling obtained in such an inquiry in North America.

To gather the information on which to base our recommendations, it was important to us to be able to listen to individuals who had actually experienced sexual abuse by physicians and to reach an understanding of that experience. We used an in-depth, qualitative approach to the gathering of our information, issuing an open invitation to the public to share their experiences, concerns, and suggestions about sexual abuse of patients with us. This approach yielded information that was rich in quality. From February to August 1991 (6 months), we heard 303 compelling reports of sexual abuse by physicians and others in positions of power and trust from our public and private hearings, letters to the Task Force, and through our 24-hour, confidential telephone line.

**The voices of those who shared their experiences with us in our hearings or by letter are presented throughout the balance of the Report.*

The experiences of the survivors who had the courage to reach out to us are presented throughout this Report and reflected in our recommendations. In this chapter, we provide a sampling and an analysis of the information we gathered.

Over the initial 6 months of its existence, the Task Force received over 350 phone calls from concerned citizens, patients, health professionals, organizations and institutions from across Ontario and other parts of Canada. Of these phone calls, 203 were to make reports of sexual abuse by physicians. All callers who requested a response received one from the Task Force Coordinator or her Assistant, a Task Force member, an Advisory Council member, or a trained counsellor. Calls from survivors ranged from two minutes to 90 minutes. In some cases, survivors left messages on our answering machine and requested that we not call them back; we respected those requests. Many callers preferred to remain anonymous; we also respected those requests.

We encouraged callers to share what they felt comfortable sharing and did not pressure them to do otherwise. Therefore, some reports were more detailed than others.

The reports of sexual abuse we heard involved physicians most of the time. However, we also heard from people who had experienced abuse by those in other positions of power and trust, including teachers, hospital administrators, clergy, lawyers, judges, therapists, optometrists, dentists, social workers and nurses.

The survivors described what had happened to them as "sexual abuse," "sexual impropriety," "sexual assault," "sexual harassment, "sexually-demeaning behaviour," "psychological abuse," "physical abuse," "rape," and "like an incestuous relationship." Some had trouble finding a name for the abuse. What they all knew was that they felt violated, angry, ashamed and afraid. This is consistent with research findings about victims of sexual assault.

The survivors described the harms caused by this sexual abuse. All of them reported that it had some significant effect on them. Many reported that the experience was devastating and left them emotionally scarred. They reported symptoms that included nightmares, feelings of guilt, shame and humiliation, fear or distrust of men, and inability to develop and maintain intimacy. We also heard that they had feelings of rage, anger, or being dirty, and had thoughts of suicide or actually attempted it. They talked about the abuse rendering them unable to parent their children. Finally, they told us about the physical symptoms they experienced - headaches, blurred vision, tremors, vaginal and anal pain, palpitations, nausea, and vomiting. All of these experiences - both physical and emotional - are consistent with what is documented in the literature on the harms caused by sexual abuse.

We learned that the extent of the harm experienced by survivors is not necessarily related to the physical nature of the abuse. For example, survi-

vors told us that, even though their abuse consisted "only" of an episode of fondling, and/or kissing, they felt violated, invaded; i.e. raped. Others told us that the manipulation and betrayal of their trust by their doctor hurt them much more than the sexual act itself.

In addition to the private and personal suffering that survivors described, they told us that the abuse also affected people close to them, because their suffering interfered so strongly with relationships. Some experiences led to family breakups, dropping out of school, unemployment, and other far-reaching problems.

Two additional messages were made very clear to the Task Force. First, many callers said that they had never disclosed their abuse before because, prior to the establishment of the Task Force, they were convinced that their accounts would not be believed or that they would be blamed for the abuse. People feel this way because society has not yet acknowledged the gravity and frequency of this sort of abuse. Secondly, patients with a history of psychiatric illness felt particularly vulnerable to the consequences of disclosing abuse. Their fears of not being believed were particularly strong. Many had summoned the courage to come forward in the past and, due to their history, had not been believed.

Why People Called

Most callers wanted to share their experiences, hoping that these experiences would matter to us. Many did not wish to file complaints or take action against the physician but to initiate a process which they believed was important to their own healing. Some needed information about the College of Physicians and Surgeons' complaints process or about the legal system. Many calls were to praise and give support to the Task Force endeavour. Needless to say, many callers wanted to use the Task Force to channel their frustrations and anger about the existing system and the perpetrators who are still practising and damaging people.

Common Themes from the Phone Calls

Calls to the Task Force were grouped into six categories:

1. Personal Experiences.
2. Third-party Reporting, i.e., someone who knew the abused patient and reported the abuse because the patient is too damaged to be able to take that step.
3. Requests to Testify or Present to the Task Force - either in public hearings or in private (where all information was kept confidential).
4. Initiatives to Begin Formal Complaint to the College.
5. Information-Seeking, Sharing Concerns and Giving Suggestions.
6. Other.

There were recurrent themes throughout each category.

Category 1: Personal Experiences

"It is the first time I have spoken to anyone about this."
"This experience damaged me badly. I have never been able to trust anyone since."
"I am afraid no one will believe me."
"I blame myself for what happened. I should have known better."
"I trusted my doctor. He had been the family's doctor for many years."
"I feel guilty and ashamed by what has happened."
"Since that happened to me, I have not been able to have an intimate relationship with a man."
"The experience deprived me of a normal life."
"I have been unable to find proper treatment since my experience. Most therapists do not understand or know how to treat patients with these problems."
"The pain never went away."

Category 2: Third-party Reporting

"Since the experience, she has been unable to speak out."
"I'm doing this because someone has to do it. Someone has to help stop these people."
"Since the experience, she has changed. She locks herself away and does not eat. She quit school."

Category 3: Requests to Testify or Present

"This, I believe, is the beginning to my healing."
"I am doing this so that people will know and, hopefully, stop him and others like him from damaging women."
"I am doing this for my daughters, my sisters, my friends and their friends."
"I am doing this to help protect other women out there."
"I am doing this for my own recovery."
"I think the public needs to know what is going on behind the doctor's closed doors."
"It is important for me to do this."

Category 4: Initiatives to Begin Formal Complaints

"I know that he is still practising and I fear that he is doing this to other patients."
"This is a difficult process and I'm ready to go through it so that this behaviour will stop." "I don't believe that the College will understand. Doctors always protect doctors."
"I filed a complaint months ago and I haven't heard anything from the College."
"I don't know what's going on with my complaint and I am wondering how the Task Force can help."

Category 5: Information-Seeking, Sharing Concerns and Giving Suggestions

"I am pleased to see a conservative body, such as the College, taking such initiative."
"I wonder what will happen when the Task Force is dismantled."
"I am happy to see the Task Force in place, but wish the Terms of Reference were broadened."

Category 6: Other

"It is not just doctors abusing; it's all the people in power and privilege."
"Good research project."

A Sampling of Reports

What follows is a sampling of telephone reports that represent the nature of the problems and concerns presented by callers. While the vocabulary was preserved as much as possible, all identifying facts were changed to maintain confidentiality.

A woman called to disclose incidents of sexual abuse by her male psychiatrist, 16 years ago. She said she was depressed and confused about a lot of things, having come from a home where she was abused. She confided in him, and he started holding her when she cried. He began lying next to her, saying that he was giving her support and help. She eventually became very afraid of him, but she was desperate to keep up her therapy. She said that there was no intercourse because he was impotent, but a lot of sexual stuff was involved. He stopped the extra-billing. She wanted to get out of it but did not know how. Finally, she told her husband, who confronted the doctor, and they both saw a lawyer. She didn't take the doctor to court or report to the Medical Council because she became "a basket case" over this and was hospitalized. All they wanted was their money back. She feels guilty for not stopping him from hurting other women, and feels the reason she couldn't stop was because she was so afraid of being abandoned.

A woman called to report sexual abuse by a physician. She said that she was abused by him and that eventually this physician lost his licence. He is no longer practising as a doctor but now is a therapist. The woman feels that with his present licence, he would be even more powerful and able to abuse.

A woman called to testify. She said she went to see a psychiatrist for the treatment of phobias - phobias about being touched. She said the doctor recommended that he desensitize her by touching her. At each treatment, the doctor would fondle and touch her. She felt that this treatment was inappropriate, but she felt powerless and so allowed it to happen. The therapy lasted for 7 years. She said she never got any better. The doctor often saw incest survivors.

A woman reported being sexually abused by a physician, later suffering from shock and ending up in the hospital emergency room. She said that her family and friends discouraged her from taking action against this doctor by saying, "You can't fight the doctor; it is his word against yours." The patient finds going to a doctor a very frightening experience. Therefore, she does <u>not</u> have medical checkups.

A woman reported that she and her husband had been seeing a psychiatrist for sexual difficulties. The psychiatrist indicated that the couple should have individual therapy, so that he could see the wife separately. From the beginning of the individual session, the psychiatrist had sexual intercourse with the patient. She remembered the doctor saying to her, "This is good for you." She described the experience as "making love to my father." She later ended therapy, but the doctor kept calling her for her to return. The woman disclosed that she is still struggling with feelings around this "shattering" experience. She later learned that other patients had similar experiences with the same doctor. She said that she reported the experience to the College but was told that it was her word against the doctor's. She feels very disappointed with this approach and does not know which way to turn.

A male called to report sexual abuse by his male psychiatrist whom he consulted for help with his homosexuality. He reported a lot of hugging. He reported the case to the police and the Attorney General's office and feels that the process is much too slow. He believes that nothing will be done to perpetrators as long as they are protected within their titles and their fancy offices.

An obese woman called to register a complaint about a male neurologist she was referred to due to neuromuscular problems. She said he never touched her, but made inappropriate sexual remarks that humiliated her. He asked her to undress for a physical exam and to squat. When she did, he said things like, "You mean your husband actually finds you attractive?" and "How often do you do it?" She was unable to get up from the squatting position and asked him for help. He refused. He told her that nothing was wrong with her. She was afraid to relay the incident to her own doctor because she didn't want him to turn against her. She was subsequently diagnosed with muscular dystrophy by another doctor, who did not ask any questions about her sex life. She is afraid that the former doctor is doing this to other women and hopes that something can be done.

A woman called to report sexual abuse of patients by a doctor who is her husband. She feels that this has been going on for a long time and does not know what to do with the information. She knows that there were complaints to the College about her husband, and is concerned that he is still abusing women.

A woman called relating an incident of sexual abuse by a male surgeon, who she had initially contacted when she was admitted to the hospital for appendicitis. She said she was discharged after three days. On her follow-up visit, he did a pelvic examination, after which they talked at his desk. On her way out, he grabbed her hand and shoulders and hugged and kissed her. She felt very uncomfortable with this and reported the incident to a family doctor and his nurse. The doctor thought that it was a one-time incident, and recommended that she keep her next appointment with the surgeon. This time he did another pelvic examination as well as a breast examination. He again hugged her and tried to kiss her, asking her to make another appointment. She also received an invitation to his house. Again, she reported this to the family doctor and left it up to him to do something. She subsequently heard that he had been charged criminally, but that the case was dismissed, as the witness did not show up. She did not want to go to the police, since she had left it in the capable hands of her doctor. She is also afraid that if she complains, she would not get another doctor to look after her.

A woman called to report sexual abuse by the doctor who she was referred to for surgery. On her first contact, he fondled her breasts, vagina and rectum. He then told her he did not do the kind of surgery she was requesting. He wrote a letter to her family doctor describing her as mentally unbalanced because she wanted this operation. She did not press charges. She wonders how accessible the College is and does not trust them since she feels they "just protect themselves." She is afraid to see a gynaecologist and feels that she has been damaged mentally since that experience.

A woman called to report what she termed, "unprofessional behaviour" by her physician over 25 years ago. He made statements which were inappropriate and of a sexual content such as, "I wonder if my penis can be big enough to satisfy you." She asked him if he talked to his patients like that, and he answered, "Yes, if they're attractive enough." Even though she was not physically raped, she felt abused. She is considering pressing charges. She thinks he should be reprimanded, and is very thankful for the Task Force being there. She is sick and tired of people who never believe "us patients." She also believes that the doctor is still practising.

A woman called to report a 10-year sexual exploitation by her social worker when she was between the ages of 15 and 25. She was anorexic and was hospitalized for one year. She was referred to a social worker on her release. The social worker told her that he could teach her all about sex. She thought he really cared about her and was really grateful to have someone treat her "special" and care about her. She kept this to herself all these years. Presently, she feels very angry and very hurt. She wants to take action, but does not know how to go about it. She was pleased to be able to talk to the Task Force members, and felt it was a start.

A woman reported that her general practitioner sexually and psychologically abused her. She said that she had been in therapy with this physician for one year. During this period, the physician tried to hold her hand and touch her legs. He also called her, "sexy," "sweet," "attractive," and "gorgeous." He offered her a job at his office. The patient reveals that she feels it extremely difficult to terminate the relationship, even if she knows that it's not healthy. She shared this experience with her husband, who is having difficulty understanding her position.

A woman called to relate an experience with a family physician when she was a child. She said that she was repeatedly abused, and so was her sister. The doctor involved was prominent, and "a pillar of society." She told her mother and family, but they told her to be quiet about it. She eventually told the police, and they said they wouldn't "touch it," because he was too prominent. She wonders how many women he sexually abused, and got away with it. She is still very nervous since the experience, and hopes that something will be done, since this doctor is still practising.

A woman called to report that she had been sexually abused by her physician several times between the ages of 16 and 18. This was a trusted family doctor. During her pelvic examination, he would make comments like, "You are really built to take a man," and he would make attempts to kiss her. He would rub her against his erection and at times, attempt to hug her. At age 18, she told her mother, and the entire family stopped seeing the doctor. Today she says, "I will never forget how awful it felt to be there."

A woman called to report an incident that occurred when she was young. She was vomiting "green stuff" and reported alone to the emergency department, where she was examined by a male physician in the presence of a nurse. A pelvic and rectal examination were done. After the nurse left, the doctor said he needed to do another examination, which he did without gloves. He also made statements such as, "You have a great pelvic floor," "You would make great babies," and "You have got a terrific inside." She felt terribly degraded and violated, and did not know what to do. She allowed him to finish and rushed away. One month later, she was diagnosed with appendicitis.

A woman called to report sexual abuse by her physician. There are now 11 women pressing charges against the same doctor. She said that when she approached the College, she was told that she did not have sufficient evidence and her case was not strong enough. She feels strongly that if action was taken, maybe many women would have been saved from this type of abuse.

A woman reported sexual abuse by a male physician. She said that the physician was a respected family doctor. One day during her checkup, he "fingered" her, and she didn't know what to say. He asked her how it felt and stopped. She never went back, and was unable to tell anyone since then. She said talking to the Task Force members was the first time she was able to reveal the story.

A woman reported a case of abuse by a physician who she went to see for a headache. She said he pulled her pants down and took pictures of her. The incident was reported to the College and for 11 months nothing was done. She is very dissatisfied, and thinks that the College is just a defence for doctors. She wonders why she cannot go to the press or police without having to go to the College. She hopes that something will be done to assist women in her position.

A woman called to report exploitation by her family physician, an incident that happened over 20 years ago. She said he examined her internally for long periods and the examinations were extremely painful. She realized that this examination was not normal and later shared this information with her gynaecologist. The gynaecologist encouraged her to write a letter to the Ontario Medical Association. So far, she hasn't had a response.

A woman called to relate an incident in which a trusted family physician gave her "innocent hugs" and one day, rubbed his genitals against her knee. Since she had experienced sexual abuse as a child, this incident has made her feel terrible and extremely uncomfortable.

A woman called to talk about sexual abuse by her physician when she was between the ages of 6 and 7. She said that she lived in a small village where there was only one physician. This physician repeatedly abused her in her home, and she believed he did the same to her brothers. This stopped when her father hid in the closet one day, and witnessed the abuse. She said that she cannot trust any doctor, be it male or female and wants a hearing.

A man called to talk about an incident of sexual abuse that occurred when he was a younger man. He said that he was seeing a female physician for headaches when she gave him a needle and knocked him out. When he awoke, she was undressed and masturbating herself. Then she put his penis in her mouth. He didn't know what to do or say and pretended to be asleep. When she was finished, he pretended to be waking up. He switched to a male doctor after this, and feels extremely uncomfortable with doctors. He said that this was the first time he talked to anyone about it.

A woman called to report an incident with her family physician which occurred 16 years ago. She said she had difficulty breast feeding her 3-month-old son and reported this to her physician. He grabbed her breast and kissed her while having an erection.

A woman reported having a sexually-abusive relationship with her psychiatrist for six months. She's been suffering emotionally ever since the experience and is unable to continue her normal life. She finds herself feeling isolated from all social contact, feeling "dirty" and at times, wanting to die. She was unable to share this experience with anyone, and took the risk to speak to the Task Force on the phone. She said that she would never be able to do this eye-to-eye. She fears that the doctor is still abusing other patients out there, and wonders what can be done about it.

A woman reported having an abortion on the advice of her general practitioner. Six months later, she returned to her general practitioner for an internal examination. At this time, the doctor stroked her clitoris. When asked what he was doing and why, the doctor replied, "to lubricate." Unable to share this experience with anyone at the time, the woman later found out that her sister had a similar experience.

A woman called to disclose an incident of sexual harassment by her physician on her first visit. She said she went for treatment for depression. The doctor grabbed and kissed her then invited her on a trip to Europe. Her fiancee encouraged her to call the Task Force to tell her story.

A woman called to report inappropriate sexual behaviour by her doctor who she was seeing for low back pain. She was seeing him for acupuncture treatments. She said that he would stay in the room and masturbate while she had the needle stuck in her back. She has since received counselling and made attempts to take this to the court system - so far, without success. Charges she made toward the physician were dropped due to technicalities, and she was told that a doctor could do whatever he wanted in his private office. Since then, she has learned of five other women who had similar problems, and were affected in similar ways. She is frustrated that this doctor is still doing this and getting away with it. She is disappointed in the system and feels very nervous about going back to see doctors.

A woman called to report sexual abuse by her doctor that occurred six years ago. She went to see him for abdominal pain, and during the examination, he tried to make her have an orgasm. She asked him why he did that, and he said he needed to do it to find out what was wrong. On another occasion, he asked her to fully remove her panties when she had a rash on her hip. She never went back but feels guilty because she didn't say, "no." She is in therapy and is now ready to fight back. It scares her to imagine that this could happen to her 12-year-old daughter. "He should not be allowed to practise."

A woman called to report that her doctor raped her anally and vaginally. He threatened her by telling her that, "No one will believe you," and "What will your husband say?" She once caught him following her, and reported this to the OPP. They said they had no other complaints. She also went to a sexual assault centre where she received minimal support. She is afraid to lodge a complaint for fear that he will come after her. Although she initially blamed herself for what happened, she now feels very angry about this.

A woman called, asking to testify. She said that she had an inappropriate breast examination. She knew that the doctor was attempting to stimulate her by the way he stroked her and the things he said to her. She believed that, in a case of this sort, the College would see it as minor, and trivialize the problem.

A woman called to say she had done 12 years of counselling, and worked with women who had abortions. She wanted to speak on behalf of women who had been abused and impregnated by physicians, and those who had been impregnated by their fathers.

A woman called to testify. She said that she was fired from her job because she reported to the administrator that a doctor on staff was abusing and harassing nurses. She felt that she could not get a job since then, and had tried many other institutions. She has been blacklisted because she took a position to report this behaviour. She believes that the system is set up to perpetuate and encourage this type of behaviour and that the people in power at these institutions are able to silence staff members.

A woman called to ask for time to testify privately. She said that in 1981 while she was in six months of therapy, the therapist took advantage of the fact that she was single, alone and depressed. She said she was encouraged to sit on the doctor's lap when he fondled her breast. The next time, they sat on the couch. Then he called her at home and said, "You must be very confused about what happened today, let's go for a drink." She said they did; nothing happened. She couldn't talk to him easily about it. She continued to see him for a few months. Then it ended. She said that she was very vulnerable and needy at the time, and she thought it was developing into a personal relationship. She was also helped by meeting someone (whom she married soon after) to whom she told this, and who was very supportive. She also shared this with her supervisor, who, she said, was supportive. She now has a therapist, and is working through the issue.

A woman called to report that when her daughter was 14-years-old, she was sexually abused by her therapist. The woman wrote a registered letter to the hospital where the therapist worked, but she got no response. The daughter, who is now 17 years old, wants to do something about this, and would like to know how the Task Force could help. She asked for information.

A woman called to report that she was abused by her therapist 1-1/2 years ago. The therapist was a minister, who holds a doctorate degree. She was concerned that he might still be doing this to others, and wondered what information the Task Force could give to her.

A woman called to report an incident that occurred with her physician when she was 14-years-old. She said that this physician was warm and caring, so she subsequently referred her schizophrenic brother to him. On her next visit, after he had seen her brother, the doctor did a rectal examination which was very painful. She pointed this out to the doctor, who, in return, said that this was a punishment for what she did to her brother.

A woman called to report that she was sexually abused by her physician. The abuse occurred about four years ago, and she feels a certain responsibility to his younger patients, who she feels are more vulnerable. She really wants to help, but is unsure of what to do. She wants direction from the Task Force.

Conclusions

The number and nature of the reports we received about sexual abuse by physicians has led us to conclude that sexual abuse of patients by physicians is a problem of significant proportion. In six months, we heard details of 303 situations of sexual abuse. However, even one situation is too many.

We believe that this abuse is wrong. We also believe that there is something fundamentally wrong with a system that allows it to continue. We believe that this wrong must be corrected. We also believe that now - not later - is the time to reach out to redress this long-neglected tragedy. This report is not intended to lay blame for what has happened. Rather, it is intended to report on what is and has been happening, and to ask that those with the power and status to make the fundamental changes required -physicians, the College, government, and the public - take responsibility for doing so.

CHAPTER 2

CHANGES IN PHILOSOPHY

In this chapter, we build upon the unanimous decision of the College Council (composed of doctors elected or appointed by other doctors and public members appointed by the provincial government) to adopt Recommendation 1 of our Preliminary Report. As a result, the College has confirmed its commitment to the safety of the public by affirming the philosophy of **Zero Tolerance** of sexual abuse, and in accordance with that philosophy, will develop policies, procedures, practices, and education programmes that support it.

In this chapter we cover the following recommendations:

Recommendation 1

a) That the College immediately establish an **Implementation Committee** to implement all of the recommendations approved by the Council of the College. That the **Implementation Committee** consists of representatives drawn from College Council and staff at all levels, and, in recognition of their demonstrated expertise, at least three representatives of the Task Force and/or the Advisory Council who are not members of the College Council. We suggest that a senior member of the College be clearly charged with the responsibility of chairing the Implementation Committee and presenting a detailed annual progress report to the public, the Minister of Health, and the College Council at its Annual General Meeting in 1992, 1993, and 1994.

b) That the Minister of Health go beyond studying the issue of sexual abuse of patients and **reinstate** her proposal to add to the **Regulated Health Professions Code** a **Patient Relations Monitoring Board** or its equivalent to evaluate implementation by the College of Physicians and Surgeons of Ontario (and soon, other Colleges), so that the Government of Ontario continues to provide effective leadership to bring about solutions to the problem of sexual abuse of patients.

That the Minister of Health, should she decide to exclude the **Patient Relations Monitoring Board** from the **Regulated Health Professions Act**, nevertheless take immediate steps to appoint an **Evaluation Team** to monitor and report annually on the implementation of the recommendations of this Task Force, rather than wait until all the other Colleges in the **Regulated Health Professions Act** have "caught up" to the initiatives of the College of Physicians and Surgeons of Ontario.

c) That the **Evaluation Team** or its equivalent present an evaluation of the College's progress to the Minister of Health and to the Annual General Meeting of the College in 1994 that contains a recommendation as to the appropriateness of continued **self-regulation** in investigating members accused of sexual abuse of patients. That the evaluation be based, **at minimum**, on:

i) the use of well-publicized public hearings to gather information;
ii) a test of the system by professionals with expertise in sexual abuse, to check that complainants and physicians feel they are being heard, and that complainants and physicians are being treated appropriately;
iii) a review of any reinstatements granted to physicians whose licences have been revoked or suspended for sxual abuse; and,
iv) whether there has been an increase in the number of sexual abuse complaints received and processed by the College, and
v) the outcome of those complaints.

The Task Force believes that compliance with the philosophy of **Zero Tolerance** must be tested. One important test will be that there are no reinstatements of licences to physicians found guilty by the College of sexual abuse, unless all of the criteria for reinstatement specified in Recommendation 24 have been met.

That, should the recommendation in May 1994 be for continued self-regulation, that the Evaluation Team or its equivalent remain in place to continue to monitor and assess compliance, making an evaluation and public report to the Minister and the College every three years.

"Every important area of my life has been significantly harmed. I failed my year at university while seeing this first psychiatrist. I continue to suffer extreme anxiety and depression; I've been underemployed all my professional life; intense hostility toward men - no children, no marriage; after nine years in Ottawa, I have no lasting friend; I cannot feel my body."

Survivor, Private Hearing, Ottawa, March 19, 1991

Recommendation 24

That the **Regulated Health Professions Act** be amended to include **two levels** of the offence of sexual abuse of patients:

I Sexual Impropriety, and
II Sexual Violation

As defined in this Recommendation,

I. Sexual Impropriety will comprise any behaviour, gestures, or expressions that are seductive or sexually-demeaning to a patient; inappropriate procedures, including, but not limited to, inappropriate disrobing or draping practices that reflect a lack of respect for the patient's privacy or deliberately watching a patient dress or undress instead of providing privacy for disrobing; subjecting a patient to an examination in the presence of medical students or other parties without the explicit written consent of the patient or when consent has been withdrawn; examination or touching of genitals without gloves; inappropriate comments about or to the patient, including, but not limited to, making sexual comments about a patient's body or underclothing; making sexualized or sexually-demeaning comments to a patient, criticism of the patient's sexual orientation (homosexual or heterosexual or bisexual); making comments about potential sexual performance during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction; requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation; making a request to date; initiation by the physician of

conversation regarding the sexual problems, preferences, or fantasies of the physician; kissing of a sexual nature.

The penalty range for Sexual Impropriety would include reprimand, apology, fine, temporary suspension of licence, with conditions or any combination thereof.

II. Sexual Violation will include physician-patient sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may be reasonably interpreted as sexual, including, but not limited to, sexual intercourse, genital to genital contact, oral to genital contact, oral to anal contact, oral to oral contact except Cardiopulmonary Resuscitation, touching breasts or genitals except for the purpose of appropriate physical examination or treatment or where the patient has refused or withdrawn consent, and encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present.

The penalty for Sexual Violation would be a mandatory revocation of licence for a minimum of five years and a fine up to $20,000.00.

That the **Regulated Health Professions Code** should be amended to include the fine and mandatory revocation of licence for a **minimum** of five years for members found guilty of Sexual Violation. Once the mandatory five year revocation had been served, the physician would be entitled to apply to the Discipline Committee for reinstatement of his or her licence to practice medicine. The **Regulated Health Professions Code** should be amended so that upon application for reinstatement, the Discipline Committee, the Council or the Executive Committee must require the applicant to fulfil specific requirements including: (see Appendix A for a detailed draft amendment)

- Having the College publish a notice of application which informs all physicians of the intention of the applicant to apply for readmission, and outlines how to contact the College with any relevant information prior to the applicant's readmission hearing.

- Providing a written brief demonstrating the ways in which readmission would be in the public interest.

- Making good all financial losses caused by his or her sexual abuse.

- Filing a statutory declaration setting out in full his or her business or employment activities during the period following revocation of his or her licence.

- Filing a certificate from his or her treating professional detailing the course of treatment entered into and stating the treating professional's opinion of the applicant's compliance with treatment goals and the success of treatment overall.

- Filing a certificate from an independent assessor who has evaluated the course of treatment and formed an opinion as to its success in ensuring that the applicant poses no danger to future patients.

- Filing a series of documents prepared by the treating professional and the assessor, including an assessment of how the abuse occurred, an outline of specific rehabilitation goals and whether or not they have been met and a list of specific changes in behaviour which have occurred through the rehabilitation process.

- Filing a re-entry plan developed by the independent assessor, which includes substantive safeguards to prevent further sexual impropriety or violation.

- Demonstrating a commitment to ongoing rehabilitation therapy, including submitting quarterly reports to the College on the status of his or her recovery.

In hearing an application for reinstatement, the Discipline Committee would be required to carefully consider each of the aforementioned documents, as well as:

- Testimony from the applicant, the treating professional and the independent assessor as to the applicant's understanding of the harm done by his or her abuse and the effectiveness of rehabilitation in this case, the specific changes in behaviour which have taken place, the commitment to ongoing rehabilitation and specific rehabilitation goals, the proposed safeguards in place should the physician be reinstated, and any practice restrictions including monitoring which are recommended.

Having reviewed all evidence regarding the rehabilitation of the applicant, the Discipline Committee must be convinced that:

- The evidence presented, including expert evidence, satisfies the Discipline Committee to a substantial degree of medical and psychological certainty that the applicant will not abuse patients or other vulnerable persons in future.

- Readmission would be in the public interest.

The Need for Change

Sexual contact between physicians and patients is not a recent development -- nor is concern about it.

Although there are earlier medical codes and texts, such as the Code of Hammurabi, which was compiled around 2000 B.C., the first concerns about physician-patient sex in a written text are to be found in the Corpus Hippocratum. This was a body of about 70 medical texts compiled by the Library of Alexandria during the 4th and 5th centuries B.C. (Sigerist, 1961)

It is not known how many of these works can actually be attributed to Hippocrates, who lived from 460 to 370 B.C., although it is quite likely that he did not write the most famous item in the Corpus, the Oath which is usually attributed to him (Campbell, 1989) In both the "Oath" and "The Physician," doctor-patient sexual intimacy is discussed. In "The Physician," the intimacy of the physician-patient relationship is described:

> The intimacy also between physician and patient is close. Patients in fact put themselves into the hands of their physicians, and at every moment he meets women, maidens and possessions very precious indeed. So towards all these self-control must be used. Such then should the physicians be, both in body and in soul. (Trans. by W.H.S.Jones, cited in Reiser, Dyck, & Curran, 1977, p.5)

The original Greek version of the "Oath", usually referred to as the Hippocratic Oath, states in part, "...and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free." (Trans. by W.H.S.Jones, cited in Reiser, Dyck, & Curran, 1977, p.5)

When the "Oath" was rewritten for Christian physicians some centuries later, this section read as follows:

> ... with purity and holiness I will practice my art.... Into whatever house I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of Mischief and Corruption and further from the seduction of females or males, of freemen and slaves.... (Braceland, 1969, p. 236)



Jane Richardson of the advocacy group About Face, speaks to the Task Force.

During the Middle Ages, the treatise "De Cautelis Medicorum," thought to have been written by Arnald of Villanova, read in part:

> Let me give you one more warning: Do not look at a maid, a daughter, or a wife with an improper or a covetous eye and do not let yourself be entangled in woman affairs for there are medical operations that excite the helper's mind; otherwise your judgment is affected, you become harmful to the patient and people will expect less from you. And so be pleasant in your speech, diligent and careful in your medical dealings, eager to help. And adhere to this without fallacy. (Braceland, 1969, p. 236)

The issue of physician-patient sex again emerges in the literature near the end of the 18th century. Concern about physicians taking sexual advantage of their patients through the misuse of mesmerism (hypnosis) was voiced in 1784 by a Commission of Inquiry headed by Benjamin Franklin, which, in a secret report to the French King, Louis XVI, stated:

> ...the danger exists...since the physician can, if he will, take advantage of his patient.... Even if we ascribe to him superhuman virtue, since he is exposed to emotions which awaken such desires, the imperious law of nature will affect his patient, and he is responsible, not merely for his own wrong-doing, but for that he may have excited in another. (Franklin, de Bory, Lavoisier, Bailly, Majault, Sallin, d'Arcet, Guillotin, & Le Roy, 1965, p.6)

Campbell Perry (1979), a professor at Concordia University in Montreal, noted that at "... the time the report was written...medical doctors enjoyed a bad reputation in the eyes of a significant segment of the lay public." (p. 188)

Erotic feelings between doctor and patient also are found in the earliest reported cases of psychotherapy — the "talking cure." Anna O. was treated using hypnosis by Joseph Breuer in 1880; subsequently, the case became one of Freud's most widely discussed models of psychotherapeutic treatment. Jones (1953), Freud's biographer, reported, on the basis of Freud's account of the case:

> ...that Breuer had developed what we should nowadays call a strong counter-transference to his interesting patient....his wife became bored at listening to no other topic,...jealous....unhappy and morose. It was a long time before Breuer...divined the meaning of her state of mind. It provoked a violent reaction in him, perhaps compounded of love and guilt, and he...[brought] the treatment to an end....that evening he was fetched back to find [Anna O.] in the throes of an hysterical childbirth...the logical termination of a phantom pregnancy....he managed to calm her down...and then fled the house in a cold sweat. The next day he and his wife left for Venice to spend a second honeymoon....(pp. 224-25)

Although this experience deterred Breuer from further experiments with hypnosis to treat hysterical symptoms, Freud went on to experiment with the "talking cure" and, eventually, to develop psychoanalysis. In his classic Introductory Lectures in Psychoanalysis, published in 1917, Freud noted the romantic and erotic feelings his female patients exhibited toward him, labelling it transference. In writing on the topic, Freud (1958) clearly indicated that the therapist should not take advantage of the patient's "longing for love" and should abstain from sexual involvement. Freud also noted that the therapist had to struggle with his own countertransference love feelings.

Despite Freud's warnings of the potentially erotic atmosphere of the psychoanalytic relationship, some of his followers experimented with physical contact with clients. When Freud learned that Ferenczi, one of his followers, had engaged in kissing and other physical contact with clients, he wrote a challenging letter on December 13, 1931, warning Ferenczi about this practice (Jones, 1953).

Wilhelm Reich (1945, pp. 126-7) believed that the therapist should allow the client's overt sexual feelings to develop until they are "concentrated, without ambivalence, in the transference." Although he never advocated sexual relationships between therapist and client, at times "[he] physically manipulated...[some clients] to 'appropriate' responses" (Marmor, 1970,

p.12). Reich (1945, p. 133) cited two measures of whether sensual genital striving was freed from repression: "Phantasies of incest without guilt feeling" and "genital excitation during analysis...." While explaining Reich's theories and behaviour as, in part, symptoms of paranoid schizophrenia, Marmor (1970, p. 12) accused Reich's students and followers of using "the prestige of this unfortunate psychoanalytic pioneer to act out their own countertransference needs."

In recent years it has come to light that psychoanalyst Carl Jung had a romantic affair with Sabina Spielrein, whom he treated from 1905 to 1909. She had been 19 years old when she began her analysis. Subsequently she became a physician and in 1912 joined the Vienna Psychoanalytic Society. Gay (1988, p. 396), in his biography of Freud, described Spielrein as "...one of the most extraordinary among the younger analysts," who:

> "...had gone to Zurich to study medicine and in desperate mental distress, went into psychoanalytic treatment with Jung.... She fell in love with her analyst, and Jung, taking advantage of her dependency, made her his mistress. After painful struggle in which Freud played a minor but not admirable part, she freed herself from her involvement and became an analyst."

"The physician-patient relationship is a special relationship in which the physician accepts the trust and confidence of the patient to act in his or her best interest with utmost care and good faith. Inherent to this fiduciary relationship is an imbalance of power. The physician has the knowledge to heal, the power. The patient, ill and seeking treatment, is dependent and vulnerable. "Do what the doctor says and you will get better," we tell our children and ourselves. Respect for patients as persons will minimize the risk of abusing them."

Dr. Rebeka Moscarello, Department of Psychiatry, Women's College Hospital, Assistant Professor, Faculty of Medicine, University of Toronto

Her relationship with Jung was discussed in letters between Freud, Jung, and herself and later was reprinted in a book by Aldo Carotenuto, first published in Italy in 1980, and then appearing in English translation (Carotenuto, 1982) as A Secret Symmetry: Spielrein Between Jung and Freud. The book generated reviews such as Bettelheim's (1983) "Scandal in the Family." In terms of physical contact the romantic involvement may have gone no further than kissing and talk of love, but Spielrein has been referred to as Jung's "mistress," implying greater sexual involvement. The rumours it generated and the subsequent interchanges between Freud, Jung, Spielrein, and others are discussed by Masson (1988, pp. 170-77).

Such transgressions were not limited to male psychoanalysts. Karen Horney, one of the leading figures in psychoanalysis, who challenged Freud's views on women, was quoted as saying:

> As a rule it is better not to have social relationships with a patient, but I am not terribly rigid about it. Generally, I have none or a restricted relationship. (Wolff, 1956, p. 87)

However, in her biography of Horney, A Mind of Her Own, Susan Quinn notes that in her later years Horney had a romantic relationship with a young man who was in treatment with her, something Quinn (1988, p. 378) attributed to "old impulsive ways [which] survived into middle age." Quinn claims that this relationship, begun during the second half of the 1940s, lasted until the end of Horney's life (1952).

Canadian psychiatric literature has provided some discussion of physician-patient sex for more than a decade. The challenge of a sexualizing patient (Sniderman, 1980), sexualized transference and countertransference in conjoint couple therapy (Guttman, 1982), and erotic transferences (Frayn

and Silberfeld, 1986) have been discussed. Carr and Robinson (1990) provided an overview in their article "Fatal attraction: The ethical and clinical dilemma of patient-therapist sex." Although it did not discuss sexual abuse of patients explicitly, a psychiatric article on "Impaired interns and residents" quotes an anonymous resident stating, "My hunger for touching, cuddling and feeling sex is agonizing." (Hurwitz et. al., 1987, p. 165)

Psychiatry's struggle has also been noted by the Canadian medical profession in recent journal articles such as "Psychiatrists confront an image problem" (Trent, 1991) and "Case involving prominent BC psychiatrist puts medical profession on trial" (LeBourdais, 1991). An article in the Canadian Medical Association Journal on "Sexual misconduct" (Rapp, 1987) generated a series of replies (Seeman, 1987; Solursh, 1987; Berger, 1988).

It is further worth noting that, in Canada, the practice of psychotherapy is not limited to psychiatrists. The Medical Psychotherapy Institute provides training for doctors who are not psychiatrists. There is a GP Psychotherapy Network which has a newsletter, GP Psychotherapist, and which reportedly had 750 members in 1989 (Canadian Medical Association Journal, 1989). Its popularity is reportedly growing (Trent, 1990).

Since the medical specialty which has been the major focus of concern regarding sexual misconduct is psychiatry, it is not surprising that the Canadian Psychiatric Association developed and published a position paper on "Sexual Exploitation of Patients" (Sreenivasan, 1989a & b).

Although this position paper suggested that because of the nature of psychotherapy, "...psychiatrists may be considered more culpable than other physicians if they engage in sexual activity with their patients," it also states:

> Physicians enjoy a privileged relationship with patients based on trust. The power and prestige of the physician, with the right to touch and explore physically and psychologically, place him or her in an advantageous position. It cannot be accepted that physicians and patients are ever similar to any consenting adults. To maintain trust, the physician must avoid initiating or responding to any forms of sexual advances. Sexualizing the relationship is a clear breach of trust. The outcome is destructive for both, but the patient suffers the greater damage as the dependent partner in the diad. (Sreenivasan, 1989a, p. 234)

This view was apparently shared by the American Medical Association which, during the same year, added a new section to the Current Opinions, Council on Ethical and Judicial Affairs, which reads:

> 8.14 Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical. (AMA, 1989, p. 34)

What is Sexual Abuse Involving Breach of Trust?

Sexual abuse involving breach of trust is probably the least understood form of sexual abuse. There now appears to be a growing understanding of

sexual abuse by a stranger - the man in the balaclava who jumps out from behind the bushes wielding a knife or a gun to sexually violate his victim - and the serious harm inflicted by this kind of abuse. However, sexual abuse involving breach of trust is not so well understood. Here, the perpetrator uses the victim's trust as a means to gain sexual access and to exact sexual compliance. Knives and guns and physical force are not necessary. The exercise of coercion based on abuse of power and authority often saves the abuser from the need to use overt physical violence (see Legal Appendix). Sexual abuse of patients by physicians and the power the physician brings to the physician-patient relationship makes opportunities for sexual exploitation more possible than in most other relationships.

"No matter how seductive a patient may be, no matter what kind of sexual feelings a patient may have, it is always the therapist's responsibility to act ethically and set limits."

Dr. G. Gabbard, author of Sexual Exploitations in Professional Relationships (American Psychiatric Press) quoted from his speech at the Clark Institute of Psychiatry, Toronto, September 11, 1991.

Patients seek the help of doctors when they are vulnerable - when the are sick, when they are needy, when they are uncertain about their physical or emotional health. The physician has the knowledge, the skills, and the expertise the patient needs to heal. The patient often suspends both judgement and personal power idealizing the doctor in order to feel secure. The physician, therefore, has more power than the patient, and this power can be used to invade sexual boundaries and to force sexual compliance. Physical force is not necessary.

What Constitutes Sexual Abuse?

Sexual abuse of patients can take many forms. It can involve rape and violations of breasts or genitals. It can involve the physician using his position of power to gain sexual access to a patient by representing sex as part of treatment. It can involve the development of personal sexual relationships that disregard the interests of the patient in order to meet the needs of the physician. As outlined in Chapter 1, Voices: A Sampling of Telephone Reports of Abuse, the Task Force heard many reports of just such painful violations.

One survivor, who was young and away from home without support systems at the time the abuse occurred, describes her experience this way:

> "One night after lights out, and the nurses had us all tucked in our beds, this doctor comes in. He did not put the overhead lights on but there was some light from a night light that was left on all the time. I can't recall if he said anything; he just cam over and put his hands under the sheet which covered me. I thought he was going to check my bandages but I soon discovered that was not the case. He started moving his hands over my body slowly and gently. I became petrified. I held my breath and tried calmly to figure out what to do. I was very afraid of what might happen next, not really knowing anything about sex as this was not a subject that was ever discussed in my home. I just knew that this was not right; that he should not be doing this to me. I was afraid to cry or scream for fear of what he would do to me. As best I recall, I made some "I'm waking up" noises and squirmed a bit like I was going to turn over. That's all I remember about him and this incident. It probably lasted only a few minutes. Perhaps he went to all the beds, I don't know. I do know that I lay awake for a long time in fear that he would come back again."

The limited understanding of sexual abuse involving a breach of trust has been a major barrier to effective self-regulation. Both the actual harm and the risk of harm to other patients posed by a physician who chooses to abuse his position of power to sexually exploit and abuse are rarely identified; moreover, when harm and risk of harm are identified, both are profoundly underestimated. Witnesses to such acts of sexual abuse are rare. The legal processes used to determine the veracity of complaints of sexual abuse must be responsive to the reality of this kind of abuse if abusers are to be found and stopped.

In the Legal Appendix to this Final Report, there is extensive discussion of the doctor-patient relationship and self regulation by the medical profession. Doctors occupy a privileged position in society on the basis of their education, status and access to resources, including legal representation provided by the Canadian Medical Protective Association. Very rarely will the patient be on an "equal footing" with the doctor - the patient's need for something only a doctor can provide automatically introduces an element of vulnerability. Since the overwhelming majority of sexual abuse/impropriety cases involve female patients and male doctors, the gender dynamic cannot be ignored. Canadian law recognizes that many relationships involve inequality of power and provides special remedies in certain situations to redress that imbalance. The Task Force has concluded that the strongest basis for challenging a doctor who has taken advantage of an unequal relationship lies in the law of fiduciary relationships. If a fiduciary duty exists, then breach of that duty is an independent basis for a patient commencing a lawsuit against the doctor, as well as being an aggravating factor in any sentencing decision in a criminal prosecution based on police charges. (Breach of Trust in Sexual Assault: Part One - Review of Canadian Sentencing Decisions, METRAC (1990, Toronto).

The fiduciary relationship has been defined as follows:

> "Where a fiduciary relationship exists, the fiduciary has a paramount duty of loyalty. A fiduciary cannot permit a conflict between the interest of his beneficiary and any other interest, especially his own. A fiduciary may not obtain a profit, benefit, or advantage as a result of his position."
>
> Ontex Resources Ltd. v. Metalore Resources Ltd. (1991)



Barbara Lent, a London family physician and member of the O.M.A Women's Issues Committee, and Pat Israel, national President of the Disabled Women's Network Canada, at a meeting of the Task Force's Advisory Council.

In Szorfer v. Chodos (1988), the Ontario Court of Appeal found that the fiduciary duty between lawyer and client was breached when the lawyer used his knowledge of the client's personal life to seduce his client's wife - clearly a case where the courts protected non-economic interests. The Supreme Court of Canada, in Lac Minerals, Ltd. (1989) approved of Madame Justice Wilson's guide for establishing when a fiduciary duty exists:

1. The fiduciary has scope for the exercise of some discretion or power.

2. The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests.

3. The beneficiary is particularly vulnerable to or at the mercy of the fiduciary holding the discretion of power.

The third aspect of this test has been commented upon by Waters, in the Canadian Bar Review (1990) noting that:

> "the vulnerability is not so much to the infliction of harm...but to abuse of the power or discretion.... Vulnerability is a third element but in the sense of being a consequence of power or discretion in one party, and the unavoidable reliance of the other party upon the integrity of the exercise of that power or discretion."
>
> Donovan Waters, Canadian Bar Review (1990)

A final determination as to whether the doctor-patient relationship creates a fiduciary duty is likely to be made in the Norberg v. Wynrib decision of the Supreme Court of Canada which is expected to be released in the near future.

The Task Force believes that there needs to be substantially greater understanding in the legal and medical communities of the nature of sexual abuse involving a breach of trust if we are going to deal effectively with the serious harm it causes.

The Task Force also believes - with widespread support of the medical community throughout North America - that there are NO circumstances - NONE - in which sexual activity between a physician and a patient is acceptable. Sexual activity between a patient and a physician ALWAYS represents sexual abuse, regardless of what rationalization or belief system the physician chooses to use to excuse it. Physicians need to recognize that they have power and status, and that there may be times when a patient will test the boundaries between them. However, because the physician has more power than the patient in the relationship, it is always the physician's responsibility to know what is appropriate and never to cross the line into sexual activity.

What is the Prevalence of Sexual Abuse of Patients?

During the work of the Task Force, many people asked us about how widespread sexual abuse of patients by physicians really is. Incidence studies are one source of data; however, existing research on the incidence of sexual abuse by physicians is limited. There are four U.S. studies which specifically look at sexual abuse by physicians, although there are more that look at sexual abuse by therapists and quote similar incidence levels. There are no quantitative Canadian studies, but because the correlation of other abuse statistics between Canada and the U.S. is high (Brickman, Julie; Briere, John, Canadian Urban Victimization Survey, 1985) it is logical to accept U.S. studies as supportive of similar Canadian experience.

U.S. Research

Four U.S. studies which examined the incidence/prevalence of sexual abuse by physicians were completed between 1973 and 1988. All are studies in which physicians self-reported, on an anonymous basis through mail-in questionnaires, whether they had engaged in sexual contact with patients.

The broadest and most frequently cited study (Kardener, Fuller, and Mensch, 1973) sampled 460 physicians in five specialities -psychiatrists, obstetrician-gynecologists, surgeons, internists, and general practitioners. The study found that 5% to 13% of respondents engaged in erotic contact (defined as behaviour primarily intended to arouse or satisfy sexual desire) or sexual intercourse with patients. From 5% to 7.2% specifically acknowledged engaging in sexual intercourse with patients.

The other three studies cover psychiatrists alone. Two of the studies covered male psychiatrists only and found that 7.9% (Hamilton and DeRosis, 1985, as quoted in Schoener et al, 1989) and 7.1% (Gartrell, et al, 1986) of respondents had had sexual contact with patients. One other study covered male and female psychiatrists (Borys, 1988, as quoted in Schoener et al, 1989) and found 7.8% of respondents had had sex with a patient or former patient.

At the time of writing this Final Report, the Task Force is aware of a major national American study recently completed by Dr. Gartrell and colleagues based on a random sample of U.S. physicians in several non-psychiatric specialties: family practice, internal medicine, obstetrics/gynecology, and surgery. While the data await publication, it is our understanding that this study will provide further evidence, via physician self-reports, of sexual misconduct within the practice of medicine in non-psychiatric specialties.



Marilou McPhedran in St. Catherines speaking about the Task Force's Preliminary Report at a physician's forum.

The Task Force provides this American information because the research has been done, and it was part of our mandate to make such information available.

The Canadian Scene

The most compelling evidence of the prevalence of sexual abuse by physicians has been the number of reports of such abuse that came to the Task Force in only 6 months, particularly when considered with evidence that, on the average, only 40% of those who are sexually abused ever report what happened to them (Solicitor General of Canada, Canadian Victimization Survey, 1985). Those who have an appreciation of the courage and risk-taking involved in disclosing one's sexual abuse were stunned at the number of reports we received.

As outlined in Chapter 1, we used an in-depth approach to the gathering of our information, which yielded data that was rich in quality. Over 6 months, we heard 303 detailed reports of sexual abuse by physicians and others in a position of power and trust (61 through our public and private hearings, 203 through phone calls to our confidential telephone line, and 39 through letters). Twenty-six of the reports were third-party reports. Sixteen reports involved sexual abuse of male patients.

Even though the College had received 108 complaints of sexual abuse over the 4 years from 1987 to 1990, the Task Force had no way of knowing how many more were "out there." The Task Force endeavoured to create an environment which would allow people to take the risk to call or testify about their experiences. We considered the 108 complaints already received by the College as indicative of a serious problem and we had a sense that it had even larger dimensions. In fact, research has suggested that only a very small percentage of victims ever file complaints, with one study indicating that the percentage may be as low as 1-3% (Schoener et al, 1989).

Quote from a survivor of physician sexual abuse:

"I've lost 12 years of my life so far."

Many sceptics have questioned us on how we could believe these reports of abuse in the absence of any "investigation." We believe because of our cumulative knowledge and experience about sexual abuse. False allegations of sexual abuse, while not impossible, are rare. In fact, the more pertinent issue in sexual abuse is under-reporting. The shame, anger, and self-blame experienced by survivors of sexual abuse and the fear of not being believed are powerful deterrents to coming forward. The hesitation of so many in sharing their experiences was very evident to the Task Force at our public and private hearings.

Do We Need More Data?

The Task Force had to ask whether it had sufficient data to competently address this complex problem. We decided that existing research evidence along with the wealth of case-related data which came to us and which was examined, as well as the testimony and input from hundreds of patients and physicians, was sufficient to proceed with recommendations for change.

The Task Force did consider the advisability of attempting to replicate the American studies in Canada. This would have been time-consuming and expensive, and we were not convinced such data would measurably alter our understanding of this problem. Many more physicians in Canada are now aware of public scrutiny due to the attention focused by the national news media on the work of the Task Force. We believe this has altered the social context of the research considerably, making it unlikely that the American methodology would yield reliable statistics.



Vuyiswa Keyi, Health Promotion Coordinator of the Centre for Women's Health spoke to the Task Force about female circumcision.

Conclusions

Based on the information that has come to the Task Force, it is simply not possible to consider that sexual abuse by physicians is a rare, bizarre, or isolated incident. Furthermore, false charges of sexual misconduct by physicians and other professionals have been studied and found to be extremely rare. Virtually none turned out to be fabrications (Schoener et al, 1989).

The existing information suggests that the vast majority of physicians are not abusing their patients. However, a significant minority of physicians are.

It is important that, in our shock and denial, we do not use the limited number of research studies or scepticism about incidence levels to rationalize not taking action to deal with the problem and the serious damage it causes. We believe there is more than sufficient evidence to establish that sexual abuse by physicians is a problem and that it needs to be dealt with urgently.

"The present system...is seen by victims as a system that is run by doctors, that is controlled by doctors, and which exists for doctors. It is seen with considerable accuracy as a system in which the victim is a mere witness,...in which only the doctors have rights. The victim has none - none whatsoever. The doctors decide whether there will be a hearing. There is no right to have a hearing. The doctors then sit as judges, in the course of a hearing, and then determine...what evidence will be called at the hearing. All the control is there, on that side. There is nothing for the victim."

Anne Molloy, Legal Counsel, Advocacy Resource Centre for the Handicapped, April 16 Public Hearing

What is the Actual Harm?

A number of physicians came to the Task Force on a confidential basis and told us of the anguish they have experienced as a result of not reporting sexual abuse by colleagues. Indeed, it was the physicians who came to the Task Force who most consistently urged us to recommend mandatory reporting of sexual abuse. One study found that knowledge of sexual misconduct with a patient by a colleague was extremely stressful on practising professionals (Brigham, 1989).

The damage to patients from various types of sexual abuse by professionals has been extensively studied and found to be substantial. While much of the published data relates to patients of psychiatrists and other psychotherapists, the research and professional literature uniformly argues that damage caused by non-psychiatric physicians in various specialties is equally serious and in fact indistinguishable from that caused by psychiatrists. (Burgess, 1981; Burgess and Hartman, 1986; Feldman-Summers and Jones, 1984).

Beyond the damage to patients, the damage to other members of their families is also problematic. (Milgrom, 1989). In fact, treatment services have been developed in several areas of the United States to assist these "secondary victims" (Luepker and O'Brien, 1989).

Health problems resulting from sexual abuse are many and varied. Symptoms may be physical, psychological and/or social in nature. All can have a detrimental effect on the overall health and well-being of a patient.

Physical symptoms can range from skeletal muscle problems: body rigidity, tension headaches, tremor of lips and hands, back pain, abdominal and pelvic pain, to those involving the autonomic nervous system: rashes, chills, ringing of ears and dryness of mouth. Also included in the latter list are conditions such as difficulty breathing, night sweats, gastro-intestinal disorders and decreased sexual drive and orgasm.

Psychological symptoms include intense anxiety, fear, panic, depression, self-mutilation, suicidal thoughts or behaviours, mood or attitude changes, guilt, anger, loss of trust in the world and society, changes in appetite, painful retriggering of memories of childhood sexual abuse or previous acquaintance or stranger assault (see, for example, Moscarello, 1990).

The list of symptoms related to the patient's social well-being can include disordered sleep or eating habits, difficulty developing or maintaining intimate relationships, social withdrawal and increased alcohol and drug abuse (see, for example, Donald et al, 1990; Harrop-Griffiths et al, 1988). Many patients, once their doctor has betrayed a vital trust, cease to be able to trust doctors or health care providers again. Some survivors we talked to found the experience of sexual abuse in the examination room so powerfully humiliating that they avoided further medical care or travelled hundreds of miles to get medical care that felt "safe" to them.

Quote from Patient who withdrew from Complaint:

"I was prepared to do this for them without any support for me, so I had to be on my own. I was used by them and left to pick up the pieces all by myself. If they had pursued me and treated me differently, I could be persuaded to participate."

One survivor we met with described her experience of abuse this way:

> "I went to a family doctor recommended by my sister in the health field for a physical at age 16. I had always trusted doctors and was constantly encouraged by teachers, family and friends to ask doctors any personal questions I needed. On my first visit, the doctor told me that he was sure that I would lose my virginity before I was 16. I was given a brochure about pap tests and sent into the examining room not knowing what would take place. When he examined me internally using a speculum, I was certain that this would take my virginity, and was afraid. However, it was when he then inserted two fingers that I protested loudly. The doctor told me that he "just wanted to see if [I] could handle a man." I left the office very upset and immediately told my mother, who was sitting in the waiting room. My mother's response was, "but he's a doctor." Her mother had had her own abusive situation with the same doctor. She had had vaginal cancer surgery and was being pressured by her husband into having sex. She spoke about this to the same doctor, who told her, "Go ahead, that's what you were made for." She then went to her surgeon, who advised her against sex because of possible dangerous repercussions.
>
> This woman now says she will never feel comfortable seeing another male doctor under any circumstances.

The societal impact of sexual abuse by physicians is also significant. Survivors we met with talked about how the abuse had blocked their education, halted their development, blocked their ability to have satisfying relationships, contributed to family breakdown, and prevented them from being able to parent effectively, to work, or to thrive. These links to larger societal problems - unemployment, family distress, and under-utilization of individual potential - have led the Task Force to believe that the harm to individual victims affects us all.

Cultural Considerations

We received presentations from men and women who were concerned about male and female circumcision, clitorectomy, and infibulation, which they experienced as sexually abusive. These procedures, however, are religiously sanctioned in many cultures.

The issues around circumcision are complex. At present, we support a ban on clitorectomy and infibulation by physicians. We also believe circumcision merits further, in-depth study by the College and urge the College to address the issue, despite its potential for controversy.

The Reality of Risk of Harm: Repeat Offenders

As part of its mandate to protect the public, the College must look not only at the **actual harm** caused by sexual abuse by physicians but at the **risk of harm to other patients** posed by such physicians. As described to the first Task Force Legal Roundtable (Marshall, 1991) the impact of each incident of abuse in combination with the propensity to abuse more than once constitutes a significant risk of harm which is rarely identified and profoundly underestimated when it is named.

Existing research on sexual abusers identifies that there is a significant risk that a sexual abuser who abuses one person will be abusing others. One U.S. study of psychiatrists who had sexual contact with their patients, for example, documents that one third of the offenders had been involved with more than one patient (Gartrell et al, 1986). Even more troubling is data from another study, this time of psychologists, in which 80% who admitted having sexual contact with patients admitted having done it with more than one patient (Holroyd and Brodsky, 1977). Another U.S. study of nonincarcerated sex offenders documents that repeat offending is the norm across all types of sex offenders, including rapists and pedophiles (Abel et al, 1987). These findings are consistent with the evidence that came to the Task Force in our hearings: reports of abuse by the same doctors who had **already** been charged and found guilty of "sexual impropriety" with other patients and then returned to practice, only to abuse again.

This reality - resisted by many who would prefer to believe that physicians who abuse do so only once - means that many patients of an offending physician are at risk, even if only one patient has been courageous enough to complain.

We believe it is crucial that policies, practices, and procedures designed to deal with sexual abuse by physicians provide **safeguards** against this **risk of harm** at any time there is a finding of guilt of sexual abuse, and at any time there is an allegation combined with evidence of abuse which constitute reasonable and probable grounds to investigate a doctor.

What We Learned in Our Hearings: Strong Dissatisfaction with the Existing System

There was a strong call for change throughout our public and private hearings. Presenters, aware of the College and its complaints procedure, were very clear about their conviction that it is the responsibility of the College to protect the public. Equally strong was the conviction that the public will only be protected when the College recognizes the dynamics and harms of sexual abuse and deals appropriately with perpetrators. We heard overwhelming consensus that the status quo is unacceptable.

One of the clearest messages we received was the perception by the public that the College "looks after its own," that an old boys' network was in operation, and that protection of the public from the harms of sexual abuse was not a real priority for the College. Presenters displayed a significant suspicion about whether the College was objective and fair.

There was strong resentment that the present College system recognized the harms the physician might experience as a result of having a patient make a complaint about him - such as trauma and lost income, status, or career opportunities - because the College identified with him, but that the College did not recognize harms to patients at all. Further, the naming of sexual abuse complaints as "sexual impropriety with a patient" in the Regulations to the **Health Disciplines Act** trivialized the traumatic effects of sexual abuse.

These perceptions had led many survivors to be sceptical if not afraid to report their abuse to the College.



Task Force member Roz Roach responds to presenters at a public hearing

The need for change was expressed particularly strongly by complainants who had actually experienced the College process. With two exceptions, the complainants we met with had found the process to be daunting, devaluing, and retraumatizing. Most described it as being as abusive and harmful to them as the original abuse. For example, their complaints were belittled or even refused by the College because "no one else had complained" about the doctor. The exposure during the hearing process of details of their sexual history or their personal problems and the re-living of the experience of the abuse was excruciating. The trivializing of the harm done to them often confirmed their worst fears that they would not be taken seriously.

The reality of the College process was experienced as a second betrayal of trust - trust complainants had placed in the College to be objective and just. Rather than providing an opportunity to feel that justice had been

done, to see that there were caring, ethical physicians, and through that to heal, complainants re-experienced abuse. Complainants described the impact on them of the College response as ranging from distress and anger to thoughts of suicide.

Our recommendations for changes in the procedures at the College (see Chapter 5, Chapter 6 and the Legal Appendix) are based on direct and detailed reports of the actual experience which has generated such a high rate of dissatisfaction among those who have complained about sexual abuse by their doctors. A number of complainants reported that their privacy was not fully respected by the College, ranging from descriptions with such detail that anyone reading the College Bulletin who knew the complainant would be able to identify her, issuing of witness fee check payments which also bore the name of the doctor found guilty, thus identifying the witness within her or his own community, and subjecting witnesses to "running the gauntlet" past media clustered outside the College and outside the hearing room where a private discipline hearing was being conducted. The Supreme Court of Canada in Canadian Newspapers (1988) has quite clearly held that the freedom of the press will not invalidate a publication ban on the identities of sexual assault complainants and their supporting witnesses in criminal cases. Many doctors have urged the Task Force to recommend extending to accused doctors the same rights of privacy. The Task Force adopts the judicial reasoning that individual privacy interests must be balanced against the many strong public interests in knowing the name of the accused and in having an open process which is reflected in the proposed Procedural Code of the **Regulated Health Professions Act** currently before the legislature of Ontario. In the 1987 Ontario High Court decision of R. v. D(G.) the Charter of Rights and Freedoms claims by an accused to equal anonymity as the complainant was rejected in the criminal context on the basis that the accused does not have the same interests as the complainant, nor is there a similar public interest in the protection of the accused's identity. In a recent decision, Chief Justice Bayda of Saskatchewan explicitly recognized the disparity of power between men and women and its implications for equality in the context of sexual assault when he stated:

> "The appellant contends that because he, an adult male, could be charged with an offence under former s. 146(1) and an adult female committing the same act upon a male under 14 years of age could not be charged, he, the appellant, is a victim of discrimination. I reject his contention. [When one examines the "larger social political and legal context" one quickly concludes that to characterize either adult males generally, or more specifically, adult males who are potential accused under s. 146(1), (whichever is the applicable group in these circumstances) as a "discrete and insular minority," a disadvantaged group in need of society's protection or nurture borders on the alarming if not the preposterous. The applicable group of males can hardly be said to be suffering from a "disadvantage that exists apart from and independent of the particular legal distinction being challenged," a disadvantage which must be displaced and righted so that they can be and feel equal to the rest of society and in particular equal to the "advantaged" females.] In comparing this group of adult males with

adult females (a comparison which is fair given that the males' claim of victimization because of discrimination based on sex) it can hardly be said that the males are a group stereotyped, historically disadvantaged or vulnerable to political and social prejudice."

(Chief Justice Bayda of Saskatchewan R.V.W.A.M.; Sask. C.C., November 15, 1989).

"A physician has the special privilege of being permitted into the most intimate aspects of the physical, emotional, and spiritual life of another human being, and the abuse of this privilege results in incredible harm...violating the trust that accompanies this privilege is the very antitheses of healing."

Federation of Medical Women of Canada

Many complainants reported to us the deleterious effects on them in the lack of input to the way in which their evidence was presented by the prosecutor and the ways in which they were excluded from the process while the doctor was allowed to be present throughout. In Recommendation 38(a) the Task Force has concluded that Intervenor status should be extended to any complainant so requesting. The essence of the argument in favour of intervention is that it will likely lead to a better decision by bringing to the tribunal's attention all the interests involved, and all the arguments that can be made. The essence of the argument against intervention is that it will prejudice one or more existing parties either through delay (which increases costs) or through a procedurally unfair "ganging up" on one of the parties. Based on legal research conducted for the Task Force, we have found no substantiation for the claims by some doctors and their lawyers that intervention in College hearings infringes on some principle of fundamental justice (see Legal Appendix).

Doctors and their lawyers have argued that mutual disclosure as recommended in the Preliminary Report would somehow take away an existing right of doctors. As the College currently conducts its disciplinary hearings, there is a totally one-sided disclosure process. The prosecution is obliged to provide detailed information on its case including a summary of what each witness is going to say, while the doctor need not provide information as to the defence to be presented. Doctors do write letters in response to the initial complaint, but they often contain no details of the defence beyond a mere denial. The defence need not even inform the prosecution who their witnesses will be (including expert witnesses) often resulting in surprises and difficulties in cross examination. Indeed, some members of the discipline panel which decided the much publicized "pelvic bonding" case (which produced a public outcry when a doctor was acquitted by the College even though he acknowledged that his "treatment" consisted of having his female patient press her face to his groin,) stated that the outcome was due to difficulties created because there was no prior disclosure by the defence to allow the prosecution to prepare appropriately. The Task Force has maintained its call for mutual disclosure. It is simply an attempt to make the process a more balanced "two-way street," and is consistent with the Law Reform Commission of Canada report which concluded that full discovery was essential for the rational functioning of an adversarial model, no matter how the proceedings were characterized (see Legal Appendix).

Dissatisfaction with the present College system also motivated presenters to press for removal of the College's power to self-regulate and to give it to an independent tribunal which would be appointed for its demonstrated expertise in dealing effectively with sexual abuse. This was seen as a necessary step in the development of a process of discipline that was truly effec-

tive, because it would create a public perception of impartiality and fairness and a feeling of empowerment for victims.

The Task Force, after seriously and carefully weighing this recommendation, has concluded that a further test of self-regulation is reasonable because of the recent acknowledgement by the College of the need to improve its practices. However, we also believe that continued self-regulation must be publicly monitored while new policies, procedures, practices, and education programmes are implemented (see Recommendation 14).

A Time for Leadership

The College of Physicians and Surgeons has assumed a leadership role in creating the Task Force and acknowledging that great change is necessary if we are to deal satisfactorily with sexual abuse. It has assumed this mantle of leadership in a society which has a very limited and unclear understanding of sexual abuse by those in positions of trust. The College will have to be very clear in the direction it takes and will not be able to look to traditional sources of leadership for models.

The courts are particularly deficient at present in their understanding of the kind of sexual abuse that involves a breach of trust. In one study of Canadian sentencing decisions where the sexual assault involved a breach of trust (METRAC, 1990), the judges did not name the breach of trust at all or only as an aggravating factor in 44% of the decisions. Another report (METRAC, 1991) documents, as institutional breach of trust, the lack of safeguards against sexual abuse provided by various social institutions in Ontario.

There is no evidence that other professions in Canada are regulating well in this area, although there are some helpful U.S. models from Minnesota, other states, and the American Psychiatric Association.

We believe that the College, in assuming this leadership role, must be the creator of innovative procedures and practices inside the College and an instigator of widespread change on the outside.

A New Philosophy: Zero Tolerance

We believe it is necessary to have a clear philosophical foundation by which to measure the appropriateness of policies, practices, procedures, and education programmes to deal with sexually abusing physicians.

On May 27, 1991, the Council of the College took a further important step by approving the Task Force's Preliminary Recommendation 1 to adopt a philosophy of **Zero Tolerance**. The Council unanimously passed a motion confirming the College's commitment to the safety of the public by affirming the philosophy of **Zero Tolerance** of sexual abuse, and in accordance with that philosophy, developing policies, procedures, practices, and

education programmes that support it (Recommendation 1 of the Preliminary Report). The Task Force believes this is a pioneering step towards the achievement of change.

Even prior to the formation of the Task Force, the College had expressed concern over the seriousness of the issue of sexual abuse by physicians and reiterated its position that sexual abuse by physicians is not acceptable.

The notion of **Zero Tolerance** of sexual abuse, which was Pat Marshall's recommendation to the Task Force, was tested and widely supported by patients, doctors, and advocates everywhere we held hearings.

What Zero Tolerance Means

Zero Tolerance is a philosophy that says that sexual abuse of patients by physicians is not acceptable and must never be tolerated. It recognizes the seriousness and extent of injury it causes to the victim and those close to him or her, the risk of harm to other patients posed by abusers, and our knowledge of the uncertainty of the outcome of current rehabilitation programmes for abusers.

Zero Tolerance means we report sexual abuse by physicians when we learn about it, investigate allegations rigorously, and work diligently to ensure perpetrators are brought to justice through a system that is equally accessible to both victim and physician.

Zero Tolerance means we do not tolerate the ways sexual abuse by physicians is implicitly supported, such as by judges who do not acknowledge the seriousness or nature of sexual abuse involving a breach of trust, the tendency by many people to disbelieve victims or to deny that such abuse could be happening where they live, or current insensitivity in the systems at the College, which fail to recognize and adjust for the many obstacles that can prevent a survivor from coming forward.

"There is not one woman, if she truly trusts her instincts, who can't distinguish between loving, compassionate care from her doctor, and his sexual transgressions. She welcomes one, feels awful from the other. And no doctor, in making a sexual move to his patient, doesn't realize he has long ceased being loving, caring, and compassionate."

Linda Rosenbaum, in a Letter to the Editor of the Toronto Star, August 23, 1991 (A24), in response to Star editorial August 12, 1991

Zero Tolerance means we work towards the development of sufficient support for victims so that they <u>can</u> come forward and they <u>can</u> heal, through, for example, the elimination of outdated therapeutic ideas that support the idea that the victim must have imagined what happened, may have made it up, or can heal by "forgetting about it" and that we work towards the development of a complaints and discipline process at the College that is fair and <u>seen</u> to be fair by both patient <u>and</u> doctor.

Zero Tolerance means we work diligently towards educating doctors <u>and</u> the public about appropriate attitudes, behaviours, and treatment boundaries, so abuse cannot occur out of ignorance on the part of either doctor or patient.

Zero Tolerance means we continue to support touch as a crucial, healing part of the practice of medicine, when that touch is caring, nurturing, and not sexual.

One of the results of **Zero Tolerance** will be heightened trust in the profes-

sion, since it is so clear what is not acceptable. While some people have expressed concerns to us that the work of the Task Force and the philosophy of **Zero Tolerance** will result in public mistrust of the profession, we believe the opposite is true. We believe that mistrust has grown with the occurrence of sexual abuse and due to the profession's silence. We believe that trust grows from clarity and from bringing the subject of abuse into the light.

Why Zero Tolerance?

We believe that **Zero Tolerance** is the only appropriate philosophy regarding sexual abuse of patients by physicians for several reasons:

1. Sexual abuse of patients is not acceptable because it inflicts serious harm.

2 It is particularly harmful in that the violation of the patient's trust makes it difficult, if not impossible, for the patient to place his or her trust in doctors or other caregivers again, providing a major obstacle to recovery.

3. Sexual abuse by a physician is a heinous abuse of the power held by physicians.

4. Tolerance of sexual abuse by physicians tarnishes public trust in the whole profession, including trust in the majority of physicians who **are** providing caring, appropriate care. The implementation of **Zero Tolerance** will result in greater trust and heightened feelings of safety by the public.

5. **Zero Tolerance** is the only philosophy consistent with protection of the public, which is the primary task of a self-regulating body such as the College.

6. **Zero Tolerance** provides a very clear standard for measuring the effectiveness of policies, procedures, practices, and education programmes designed to deal with sexual abuse by physicians. This will facilitate effective change.

7. **Zero Tolerance** also provides an extremely clear standard of acceptable conduct. It clarifies where the appropriate boundaries in a physician-patient relationship are and will result in an increase in awareness of the presence of sexually demeaning attitudes and behaviour. The lack of ambiguity and the predictability of what should and will flow from the philosophy is the fairest way to communicate to members of the profession the parameters of acceptable conduct.

Implications of Zero Tolerance

The adoption of a **Zero Tolerance** philosophy implies broad-reaching changes to the status quo:

- **Changes in Medical Education.** A **Zero Tolerance** philosophy will support the creation of new training programmes for medical students **and** practising physicians on the nature and dynamics of sexual abuse. Medical education on male and female sex role socialization, issues of sexuality, boundary setting, race and class issues related to abuse, and the implications of these for medical treatment will reduce some of the conditions for the perpetuation of abusive practices (see "Education for Physicians," Chapter 3).

- **Changes in Practices that Perpetuate Sexual Abuse.** It is the College's responsibility, under a philosophy of Zero Tolerance, to ensure doctors are informed of the practices that perpetuate sexual abuse such as:

    - The lack of consideration of sexual abuse as a cause in patients with symptoms such as upper gastro-intestinal problems, headaches, eating disorders, depression, and multiple personality disorder, or the failure to ask directly about sexual abuse. These practices delay healing for survivors because they do not get the treatment they need;

    - The tendency to disbelieve reports by patients of sexual abuse by doctors and other health professionals;

    - The rush to support colleagues charged with sexual abuse with character references that do not recognize the irrelevance of public behaviour to the existence of sexual abuse and the risk of harm to other patients if an abuser is left in practice.

- **Changes at the College.** Recognition of the true harm of sexual abuse by physicians and the need to remove abusers from the profession will bring a number of changes to the College:

    - Facilitation and encouragement of reporting, by victims and by physicians who have knowledge of abuse (see "Reporting" in Chapter 4 for more on the background and need for mandatory reporting by physicians);

    - Training and revamped hiring and appointment practices for College staff and Council members to build understanding of sexual abuse (see "Education for the College," Chapter 3);

    - Selection and training of prosecutors to build expertise in sexual abuse (see "Education for Prosecutors," Chapter 3);

    - Review and revision of the process of investigation and the complaints and discipline procedure at the College (see Chapter 5, "Changes Inside the College").

- **Changes in Adjudicators**. Expert testimony in sexual abuse cases frequently contains bias, misinformation, victim blaming, and

misleading reassurances about an alleged offender's behaviour. Adjudicators' acceptance of this kind of expert testimony is currently a key factor in perpetuating sexual abuse. Adjudicators need training in identifying the sources of bias and misinformation and the highly manipulative and ruthless ways abusers escape detection.

- **Changes in Penalty. Zero Tolerance** implies the development and implementation of penalties for sexual abuse that more appropriately recognize the harm caused to patients and existing knowledge about the extent to which offenders can be rehabilitated (see "Penalties for Abusing" and "Can Abusing Physicians be Rehabilitated?" later in this chapter).

- **Changes in Institutional Practices. Zero Tolerance** also implies the development and implementation of effective safeguards inside health care institutions such as hospitals, psychiatric facilities, and nursing homes that specifically protect the public from sexually abusing physicians who may choose to abuse there (see Chapter 6).

- **Changes in Laws.** The shift in values required by **Zero Tolerance** requires review and revision of laws and government policies (see Chapter 6, "Changes Outside the College" and Legal Appendix).

Concerns About the Abolishment of Legal Safeguards for Doctors Charged with Sexual Abuse of Patients

Some doctors and lawyers who responded to the Task Force's Preliminary Report expressed concerns that a philosophy of **Zero Tolerance** and the kinds of changes recommended by the Task Force would lead to a dangerous denial of "due process" to doctors or a presumption of guilt rather than innocence for a doctor against whom a complaint of sexual abuse had been made.

Zero Tolerance does **not** mean these things. When there is systemic bias, every remedy or change suggested is going to be magnified when looked at through that bias which is the status quo. Every change or new initiative is therefore seen as larger than it really is.

What our recommendations under **Zero Tolerance** really do is begin to balance the rights already enjoyed by doctors to legal safeguards with the rights of the public to safety from abusing doctors (see Legal Appendix).

Does Zero Tolerance Mean the End to Caring Physical Contact with Patients?

The value of nurturing, supportive physical contact with patients, such as holding a patient's hand in times of pain or a reassuring touch, is well-established and an important part of good patient care. The philosophy of **Zero Tolerance** is **not** intended to discourage or eliminate it, and need not do so if physician and patient communicate about whether such touch feels appropriate to the patient.

Touching can be done in ways that respect the needs of the patient. Here is an example supplied by a doctor: "I know that this is a very painful time for you, and that you're feeling scared, and I want to let you know I'm here to help - is that O.K. with you?" followed by a touch or other non-sexual physical contact.

Physicians and patients of all ages know the difference between caring and exploitative relations, "good" and "bad" touch, sexual and non-sexual contact. The philosophy of **Zero Tolerance** is designed to make it easier for both physician and patient to feel confident about the kind of touch that is appropriate because it provides an increased level of clarity.

Monitoring the Effectiveness of Self-Regulation

"One of the factors that we do know increases the subsequent likelihood to re-offend is access to potential victims under circumstances which replicate where offending initially took place. Thus allowing an offending school teacher to re-enter the teaching profession after treatment maximizes the possibility that treatment benefits will disappear."

William Marshall, Ph.D., Director, Kingston Sexual Behaviour Clinic Professor, Queen's University

In Preliminary Recommendation 14, the Task Force proposed that the implementation of the **Zero Tolerance** philosophy be monitored by an **Evaluation Team** made up of the College, the Ministry of Health and outside specialists. That process is already underway. The Task Force has been impressed with the leadership already exhibited by the Minister of Health and her government as well as the opposition parties. At the time of writing this Final Report (October, 1991) the proposed **Regulated Health Professions Act**, (RHPA) is currently before the Standing Committee on Social Development for clause-by-clause debate. The Task Force made a presentation to the Standing Committee at the end of August and shortly thereafter, the Minister of Health announced to the House that the Ministry of Health would have a policy of **Zero Tolerance** of sexual abuse and stated that it was her goal to "enact a law that will deter sexual abuse, bring abusers to justice and treat victims with greater sensitivity and respect." Following the Minister's statement, her Parliamentary Assistant announced on September 23, 1991 the following two commitments:

> "So immediately upon release of the Final Report [of the Task Force on Sexual Abuse of Patients], now scheduled for late November, an interministerial working group will conduct a consultation with all interested professional groups and public interest groups. We hope a consensus will emerge from this consultation, though we recognize it may be necessary to make unpopular decisions and are prepared to do so. ...
>
> "We are proposing the creation of a new statutory committee, the Patient Relations Committee, and will be requiring every College to institute aprogram aimed at preventing sexual misconduct within one year of proclamation of the bills. The effectiveness of each College's program will be evaluated by a **Monitoring Board** composed of members of the public and representatives of the professions. The **Monitoring Board** will be required to make an annual report which must form part of the annual report of the College that is tabled in the Legislature." (Mr. Paul Wessenger, Parliamentary Assistant to the Minister of Health, Monday, September 23, 1991).

We are also recommending that, within the College, an **Implementation Committee** be established immediately. The **Implementation Committee**

would present a detailed progress report to the public, the Minister of Health, and the College Council at the Annual General Meeting in 1992, 1993, and 1994 (Recommendation 1(a)). Only well-defined criteria should be used for the assessment of the effectiveness of self-regulation and compliance with a philosophy of **Zero Tolerance**. At minimum, these criteria need to be:

- The use of public hearings, with a requirement that sufficient "notice of public hearings" be given, in order to gather accurate information from the public

- A test of the system by professionals with expertise in sexual abuse, to check whether Task Force recommendations have been substantially implemented and if not, why not; and to assess how doctors and patients perceive the fairness of their treatment in sexual abuse complaints

- That there are no reinstatements of licences of doctors found guilty of sexual violation unless they meet to the satisfaction of the Discipline Committee the stringent criteria outlined in Recommendation 24, until rehabilitation programmes and experience can establish success in rehabilitation and identify **prospectively** that a particular individual will not abuse again.

Can Abusing Physicians be Rehabilitated?

Perspective

"We can make statements about who is not a good candidate for rehabilitation, but can be less sure about who is."

Lana Stermac, Ph.D. and Steven Hucker, M.D., Clarke Institute of Psychiatry, June 20 Public Hearing

The Task Force has listened to significant debate about whether or not physicians who sexually abuse can be rehabilitated. We have heard from a number of experts in the field of rehabilitation and have studied the literature. We have also met with survivors of abuse by physicians who had previously been disciplined, judged by the College to be rehabilitated and returned to practice, only to abuse again.

The mandate of the College is to protect the public. Therefore, the perspective from which we have reviewed rehabilitation is **not** simply whether or not an abuser is "treatable" or entitled to rehabilitation. Rather, the issue is whether rehabilitation can be successful and extensive enough to return him to practice without **risk of harm** to future patients. This implies that it must be possible to identify prospectively (not retrospectively) doctors for whom rehabilitation will be successful. It also implies a very high degree of certainty that this will be the case.

Existing Knowledge about Rehabilitation

Currently, there is no literature that specifically looks at the effectiveness of rehabilitation programmes for physicians who have sexually abused their patients.

Existing evidence indicates that treatment for sex offenders can be beneficial. However, not all programmes are effective and no approach offers total success (Report of the Working Group on Sex Offender Treatment Review, 1990). Treatment strategies generally focus on managing the risk of reoffending, through various forms of therapy and behaviour modification work. Sometimes antiandrogenic drugs are used, which curb sex drive by reducing the level of male hormones in the body, but these are problematic in that they rely on the compliance of the abuser in taking them. There is general agreement in the treatment community that more research on sex offending and more outcome data are needed.

Empirical evidence indicates that as many as 60% of treated abusers relapse (Stermac and Hucker, June 20 Public Hearing). The limited effectiveness of detection mechanisms makes tests for recidivism inaccurate. This inaccuracy is compounded by the power of an abusing doctor to silence his victims and thereby suppress information of further offending. Clearly, then, while treatment may reduce the risk of re-offending, it does not eliminate it.

"To suggest, as some might, that allowing treated physician offenders to return to practice if they are carefully monitored or supervised is to overestimate human diligence. Invariably, such supervision is not at all strict. In the possibly rare circumstance where another health worker takes the directive for supervision seriously, their diligence cannot be expected to last for more than a few months at best."

William Marshall, Ph.D.

Experience also has shown that while offenders can be treated, the basis for determining who among the treated patients will not re-offend is not well developed.

Further, we are not yet able to predict with any real accuracy whether a **particular** individual will reabuse. Experience has shown that many abusers can be very good at convincing others, particularly colleagues, that they are innocent, remorseful, or won't abuse again. These same abilities to manipulate others were often used to facilitate the abuse in the first place, and can be used again.

A major component of current rehabilitation programmes is relapse prevention: assisting abusers in identifying and understanding the circumstances under which abuse occurred, and teaching them how to avoid these high risk situations. To allow a physician who has abused back into practice has been called "asking for trouble" (Globe and Mail, July 1991).

Returning an abusing physician to practice places him in a high risk situation with the power and status to gain access to potential victims. We believe this can only be acceptable if the College has assured itself that the physician has successfully met all the criteria outlined in Recommendation 24.

Conclusions

The Task Force has reviewed every file where the College has made the decision to reinstate a physician found guilty of sexual abuse of his patients. We have concluded that, in every case, the decision to reinstate was based on insufficient evidence that patients of the reinstated doctor would not be at risk. In other words, the public has not been adequately protected by the College's decisions to reinstate these doctors. In fact, the Task Force found itself meeting with victims of abusing physicians, where the abuse had taken place subsequent to those physicians' reinstatement by the College. Their reinstatement had been based on assurances by other doctors that the abuse would not recur, when in fact, it did.

The Task Force has concluded that, given the early stage of development of rehabilitation today, the risk of harm in returning an abusing physician to practice is significant, even if he has had extensive therapy or completed a rehabilitation programme. We also believe that the programme development and testing required to improve the state of knowledge must be extensive and will probably take years to assess.

We have also concluded that **any** assessment of whether it would be appropriate for a convicted abuser to re-enter medical practice would need to be based on substantial evidence of change in behaviour and the ability to guarantee in advance that the abuser would never abuse again. In order to protect the public interest, the College must base a decision to lift a suspension or reinstate on expert evidence which meets a high standard. The kinds of criteria which we believe must be met before a physician previously found guilty of sexual impropriety or sexual violation could be allowed back into practice, include:

"We can certainly say that if an offender has effectively participated in treatment and has demonstrated changes on all the indices evaluating treatment effects, then he is at low risk to reoffend. We cannot, however, say that he is "cured" and will never reoffend."

William Marshall, Ph.D. Director, Kingston Sexual Behaviour Clinic Professor, Queen's University

- That the evidence presented, including expert evidence, satisfies the Discipline Committee to a substantial degree of medical or psychological certainty that the applicant will not abuse patients or other vulnerable persons in future.

- That re-admission would be in the public interest.

- That the physician-applicant:

    - has acknowledged the harm of his actions and made good any losses to his patients;
    - has come to understand why the abuse occurred, and been able to show evidence that the conditions leading to the abuse will not occur again;
    - has participated in an approved rehabilitation programme with specific treatment goals, and has complied with and met all goals;
    - can show evidence that his behaviour relevant to the abuse has changed and will remain changed;
    - has a plan for re-entering practice, which includes substantive safeguards that will be effective in preventing re-abuse;
    - can demonstrate commitment to ongoing rehabilitation therapy and monitoring by the College.

Penalties for Abusing

Review of Historical Penalty Decisions

As part of our review of the effectiveness of the College's policies, practices, and procedures in dealing with sexual abuse, we reviewed the outcomes of the 44 discipline hearings for professional misconduct involving "sexual impropriety with a patient" in the 11-year period of 1980-1991. In addition, the Task Force reviewed the files of approximately 25 closed cases of sexual impropriety which the College made available to us. Some of these files were selected by the College on a random basis. Some were specifically requested by the Task Force.

The outcomes from the 44 discipline hearings were as follows:

Of the 44 discipline hearings:
27 findings of professional misconduct
14 not guilty 3 withdrawn

Of the 27 findings of professional misconduct:
4 reprimanded
1 fined $5,000
11 licences suspended*
7 suspended for a period less than 12 months
2 suspended for a period from 12 months to 23 months
2 suspended for a period of 24 months or more
11 licences revoked**

Of the 27 found guilty of professional misconduct:
15 appealed 12 did not appeal
Of the 15 who appealed:
4 successful (2 appeals allowed, 2 penalties greatly reduced)
5 dismissed
3 abandoned
3 outstanding

***Suspension:** the physician does not need to re-apply to the College but may resume practice automatically as soon as the suspension period is over or when any conditions attached to the suspension are met.

****Revocation:** the physician may only regain his licence if re-instated by the Discipline Committee. He may reapply for a licence one year after revocation. From 1980 to February 1991, the College revoked 12 licences for "sexual impropriety", and reinstated one, applying conditions to the licence. (Source: College Discipline Statistics)

Other Key Findings

We met the subsequent victims of doctors returned to practice after discipline by the College. These situations made clear to us the ineffectiveness of the penalties assigned in the past for sexual abuse. Here are two examples of the cases we reviewed:

A. This young woman was referred to the doctor for therapy because of normal adolescent acting out with which her parents had trouble dealing. The doctor trained her to submit sexually and manipulated her family to collude with him. He also programmed her to suicide if she ever told anyone about the abuse.

During the "treatment", he involved her parents in a family session every other week, in which he discredited her with them by infantalizing her in front of them, lying to them that she smoked in individual sessions, and suggesting that her parents cut off her allowance for running away (which she had done shortly after the sexual abuse began). During

sessions alone with her he was sickly sweet. He sat too close to her, clasped her hands, pressured her into sitting in his lap, and eventually forced intercourse on her. She ran away from home to try to escape. Her parents then cut off her allowance. He coerced her into taking money, and then told her it cheapened her. He used this to convey she was a willing participant in the abuse and to keep her silent.

The young woman tried to stop the abuse several times. She ran away from home; she attempted suicide several times. Eventually, she was able to break away from the doctor.

She is now in therapy again and recovering. She still suffers from anxiety and depression, difficulty trusting others, vomiting in potential sexual encounters, and strong suicidal impulses whenever she talks about the abuse.

This same doctor had previously been found guilty by the College of "sexual impropriety" involving impregnation of an adolescent girl. He was suspended for 12 months, with monitoring by a psychiatrist. He returned to practise after 8 months. The psychiatrist, who "treated" the doctor monthly assured the College that there were "no worrying aspects" about him.

B. This woman was raped by her surgeon at his office during her first post-operative visit after abdominal surgery. She remembered being shocked by what seemed to be lust in his eyes during his first pre-operative examination while she was in the hospital. However, she refused to believe that he could really have sexual intentions. Her appointment at the doctor's office was late in the afternoon. The secretary told her to go in and change. The change room had a huge mirror on the right side of the wall which she found rather odd. The doctor came in and examined her; the procedure seemed normal even though she was in a lot of pain from the unhealed wound. He told her to lean forward, and to her horror, he penetrated her vagina with his penis which had blood when he withdrew. He then handed her a kleenex and told her to wipe herself. She closed her eyes out of shame, disbelief, and total embarrassment. He then said "that was good". She suffered physically from the surgery and psychologically from the rape. She complained to her family doctor who said nothing. She became suicidal and slashed her wrist; she survived and was placed under psychiatric care. She told her psychiatrist about the rape. He also said nothing. She felt that there was nothing that she could do.

This same doctor had already been disciplined by the College for a similar offence with another patient, and allowed to return to practice after his treating psychiatrist assured the College that he was fine.

We found that the lack of severity of penalties imposed by the College reflects a profound under-appreciation of the harm done to victims. This appears to be happening for three reasons:

1. Lack of understanding of the nature and impact of sexual abuse of patients and the risk of harm to other patients on the part of College staff, the Complaints and Discipline Committees, and College prosecutors, due to insufficient training (see Recommendations 6 and 27, designed to address this area).

2. The broad range of choices for penalty for "sexual impropriety" allowed to the Discipline Committee in the current **Health Disciplines Act**, including reprimand, fine, suspension of licence, restriction of licence, revocation of licence, or any combination thereof, resulting in gravitation to lesser penalties.

3. The practice of some discipline adjudicators, of making their own subjective judgement on what the experience of abuse must have been like for the victim, instead of respecting the **actual** impact of the abuse on the victim. Prejudging victim impact can lead to inappropriate assignment of penalty and is biased. It is also retraumatizing for victims since it invalidates their experience of the abuse and can be severely detrimental to their recovery.

In Task Force discussions with past and present members of Discipline and Complaints Committees, we were impressed by how determined some still seem to be to discredit the patient's experience of abuse. The following case illustrates how this attitude still operates throughout the College. The doctor in this case was subsequently charged criminally for sexually assaulting many of his women patients:

> This woman was referred to a senior proctologist by her gynecologist. The reference was for consultation about pain that had developed after an extended weekend car trip. She merely wanted to find out what the problem was and what the options were for treatment. When she arrived for the appointment, there was no one else in the office, no one in the waiting room, and no receptionist. She was given a general medical interview including psychological questions that she felt had no bearing on her reason for the visit. She was made to remove her lower garments in his presence with no screened area provided. She was then asked to sit on an examining table that had obviously not been changed from previous patients. The doctor pulled up her camisole and sweater, unhooked her brassiere, and conducted a breast examination. She was then asked to lie down while he proceeded with a full vaginal investigation. The pain from the exam was very intense, and when she protested, he said it was supposed to hurt because he was pinching her ovaries. She was then asked to re-position herself for a rectal examination. The doctor took a look externally and told her there was a tag with a blood clot in it that needed removing. She told him that she was not prepared to have this procedure done, but he said that it was "no big deal" and proceeded to anaesthetize the area. She screamed loudly, and demanded that he stop, but he told her to "hold still" and gave her an injection. Halfway into the operation he informed her that she would have to stay off her feet for three days to a week.

Once surgery was completed, he wiped blood from the area with a kleenex and then shoved the kleenex into her vagina. He then proceeded with a sigmoidoscopy without informing her what was about to happen. She protested loudly but the louder she protested, the more forcefully he maneuvered the scope to induce greater and greater pain. She was gripped with terror, as she realized that she was alone in a house with a doctor who was acting like a sadist. With the sigmoidoscopy completed and the woman still face down on the examining table, she turned her head to see what was happening. She saw him preparing a syringe and questioned his intentions. His reply was, "I won't tell you dear". She insisted that she be told what was going on, and he again replied, "I won't tell you dear or you'll go off the wall." She jumped off the table despite his efforts at restraining her. She was visibly upset, and he said "God gal, you are right off the wall" and gave her several one-armed bear hugs. He then opened a cupboard, brought out a bottle of sherry and poured her a drink. When she reminded him that she had not given consent to his examinations and surgical procedure, he told her that he could not tell her what he was going to do with the syringe until he had taken a look. He told her that it was for hemorrhoids. She later found out she doesn't have hemorrhoids. The woman immediately went back to her gynecologist and told him that she had been raped anally. He told her, "no, no, that's not rape". She started to dig for information about the doctor. She found two other women who had been abused by him. She also learned that another woman had made a complaint of sexual abuse against him which had been dismissed by the College.

She wrote to the College. It was a second letter to the College informing them she felt that she had been raped by the doctor. The College Complaints Committee dismissed her complaint. They told her that her charges were "general and non-specific". She contacted the police who laid charges against the doctor on her behalf; hers was one of eleven charges against him, dating back to 1969. The trial is in progress.

Conclusions

The Task Force has concluded that existing policies, procedures, and practices related to penalties for sexual abuse of patients are not effective, and that change is needed.

First, there is need for an improved mechanism to ensure that penalties for sexual abuse of patients are appropriate, given the serious harm caused by this abuse and the **risk of harm to other patients** posed by abusers.

Second, there is need for the **patient's** experience of the abuse to be seriously considered in determination of penalty.

There is also a need to remove euphemisms for sexual abuse such as "mutual petting" and "sexual relationship" from the records kept on sexual abuse at the College, since this language trivializes the experience of the abuse.

Finally, there is need for the adoption of the clear definitions of sexual abuse proposed by this Task Force: I. Sexual Impropriety and, II. Sexual Violation.

Recommendations

The Task Force is recommending changes in penalties for physicians who sexually abuse patients, as outlined in Recommendation 24. The approach features three recommendations:

- The creation of two levels of abuse for penalty determination: Sexual Impropriety and Sexual Violation (see Recommendation 24).
- The introduction of differences in penalty depending on the level of abuse.
- The implementation of these changes to be achieved via amendments to the **Health Disciplines Act** or its successor, the **Regulated Health Professions Act.**

Basis for Two Levels and Harsher Penalties

Why Two Levels?

- Two levels a) provide a mechanism to relate penalty to the nature of the abuse and create a distinction that will ensure a more severe penalty for more severe forms of abuse and b) provide the clearer definitions for sexual abuse that we believe are needed.
- The two-level approach uses the existing terminology of "Sexual Impropriety" to aid in transition to the new system, although its definition is now more limited in scope. The Task Force considered names other than "Sexual Abuse" which we used in our Preliminary Report for the second level, because many people told us that the use of the generic term sexual abuse was confusing. We are recommending that the second level be defined as **Sexual Violation.**

Why These Penalties?

The Task Force believes that the penalties outlined are consistent with the implementation of the philosophy of **Zero Tolerance** of sexual abuse already adopted by the College.

Sexual Impropriety

We have concluded that a range of penalties including reprimand, fine, apology, suspension of licence (with conditions) or any combination thereof is appropriate for the offences defined as "Sexual Impropriety."

We also believe that a penalty of **mandatory revocation of licence for five years** with stringent conditions required to achieve reinstatement, while severe, is appropriate for the offence defined as "Sexual Violation" for several reasons:

- A physician who has sexually violated has committed an act that has inflicted serious harm, often including illness, to his patient. He has disregarded the health and well-being of his patient in pursuit of meeting his own needs. This is the antithesis to healing and appropriate patient care.

- A physician who has sexually violated has also seriously betrayed the fundamental trust society places in a member of the medical profession. This damages the integrity of the profession as well as harming the individual patient.

- Rehabilitation programmes for sexual abusers are not developed to the extent required to ensure an abuser no longer poses a risk of harm to other patients, **especially when we cannot identify prospectively that a particular individual will not re-offend** even after attendance at a rehabilitation program. The recommendation allows for the exceptional case where a physician-abuser may be able to demonstrate complete and certain recovery.

- The penalty does **not** remove any legal right the physician may have to earn a livelihood. Rather, it removes the **privilege** of practising medicine and the privilege of receiving the public's highest level of trust (see Legal Appendix).

Other options considered but rejected by the Task Force for the penalty to be assigned to Sexual Violation were:

- A Lighter Penalty for "First Offenders." Not recommended because the injury caused by any sexual abuse is significant and must be recognized in penalty. A lighter penalty would not provide a clear message that sexual abuse of patients is **never** acceptable, and therefore, would be inconsistent with a philosophy of **Zero Tolerance**. Most important, given that an abuser may well abuse more than once, and given the low level of reporting of sexual abuse by patients, it is hard to be sure that a "first offence" is any more than a first charge.

- Restrictions to Practice (e.g. restrictions to pathology, laboratory testing, male patients only). Not recommended because the title of "doctor" always provides access to patients and to trust, and hence, to the potential to abuse again. Although the Task Force heard doctors discount this, doctors are afforded special status in our society. We are not satisfied that sufficient safeguards can be built in to effectively protect the public against this risk.

- Supervision in Practice. Not recommended because experience has shown it to be ineffective in preventing the re-occurrence of abuse by health professionals.

  Experience with the use of direct observation in supervision plans approved by regulatory bodies has been demonstrated to be insufficient protection for the patient, even when the observer is, in fact, present something quite difficult for the College or a court to monitor and ensure (Schoener et al, 1989 "Problems in the Use of Direct Observation in Probation Plans for Professionals Who Have Sexually Exploited Clients. Pages 447-449.)

  This experience is consistent with reports to the Task Force. We heard reports of abuse where the patient was abused while a nurse was present; the nurse did nothing about the abuse or removed herself from the room while the abuse took place.

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CHAPTER 3

CHANGES IN EDUCATION FOR PHYSICIANS, THE PUBLIC, AND THE COLLEGE

In this chapter, we cover the specific thinking behind the following recommendations:

Recommendation 2

> *"[The doctor] stated that he believed [the survivor's] story, but, on the other hand, he found it hard to believe that his friend [the doctor alleged to have abused] could do such things ... I believe this episode is an excellent example of the denial which I suspect is rampant inside the medical community, where belief is side by side with disbelief, and the two sides are never really integrated, leaving a kind of dissociated state within the individual's mind that would preclude taking any convincing action to firmly confront the abusive behaviour of one's colleagues"*
>
> *Communication to the Task Force by a psychiatrist currently treating a survivor of sexual abuse*

That the College initiate changes in medical training at all levels, including undergraduates, interns, residents, fellows, faculty, practising physicians, and foreign medical graduates to increase the time and content devoted to curriculum on sexual abuse, **and** that this training be included in examinations and accreditation throughout training and practice.

That the curriculum developed must reflect an understanding of the context in which sexual abuse and sexual abuse by physicians occurs, including: gender socialization, sex roles, women's equality issues, cultural variables, and the position of power the doctor brings to the doctor-patient relationship. It must also encourage development of healthy feelings, values, and self-awareness about sexuality. At minimum, the following subjects must be covered:

Improved Treatment for Sexual Abuse Survivors

- Knowledge of the magnitude of the problem of sexual abuse and sexual abuse by physicians, the consequences to victims, and issues of race, gender and class related to abuse.
- The range of problems with which victims of sexual abuse and sexual abuse by physicians present.
- Barriers to disclosure and how to facilitate disclosure.
- Management and treatment options including the need for specialized training to treat sexual abuse survivors effectively.
- The importance of checking for sexual abuse when history-taking, when this is appropriate, and how to do it appropriately;
- Strategies for recognizing, confronting, and treating abuse by colleagues and how to report knowledge or suspicion of abuse by colleagues.
- How to sensitively recognize and treat patients who, because of past sexual abuse or trauma, might perceive their physician's genuine concern as alarming and a threat to their integrity, and how to handle this appropriately.
- The recognition and appropriate care of victims of female circumcision.

- How to set and enforce appropriate treatment boundaries for oneself and the patient.

- How to discuss sexuality and sexual issues and how to perform examinations in an acceptable, non-abusive manner.
- How to give care and comfort, including touching, in an appropriate non-sexual manner.

- How to get help for oneself before abusing, including how to recognize signs in one's own behaviour that indicate that sexual abuse of a patient may occur.

Recommendation 3

That the College move swiftly to ensure that practising physicians also know:

- That, due to the power the physician brings to the physician-patient relationship, there is no such thing as gaining consent for sexual involvement with a patient.

- The warning signs of behaviour that indicate that sexual involvement with patients may occur, and what to do to prevent abusing.

- That a physician has a right to refuse to examine any area of the body of a patient or to terminate the relationship, if the physician feels that the patient is sexualizing the relationship, and how to do this appropriately.

- Where survivors of sexual abuse can find effective treatment.



Dr. Harvey Armstrong, member of the Task Force, responds to a question at a public hearing

- The physician's legal obligation to report sexual abuse by another physician (as proposed in Recommendations 15 and 16).

- The nature of the offences of sexual impropriety and sexual violation, as outlined in Recommendation 24.

Recommendation 4

That the College initiate the establishment of a **Joint Education Committee** on sexual abuse to develop and implement the necessary curriculum changes, methods of teaching, and accreditation/ examination processes. Membership on this **Joint Education Committee** must include senior representatives of the following groups and organizations:

a) Government, including: the Ministry of Colleges and Universities and the Ministry of Health.

b) The medical community, including: the Ontario Medical Association (OMA), the Council of Faculties of Medicine, the Medical Council of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Psychiatric Association, the Ontario Psychiatric Association, the College of Family Physicians of Canada, the Ontario College of Family Physicians, the Association of Canadian Medical Colleges, the committee planning Education of Future Physicians of Ontario (EFPO), the General Practice Psychotherapy Network, and the Ontario Hospital Association.

c) Front-line advocacy organizations with relevant expertise, including: the Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN), the Metro Action Committee on Violence Against Women and Children (METRAC), the Disabled Women's Network Canada (DAWN Canada), the Ontario Native Women's Association, and the Coalition of Visible Minority and Immigrant Women.

We suggest a sub-committee made up of the College, the Council of Faculties of Medicine, the OMA, the Ministry of Health, the Ontario Psychiatric Association and at least three advocacy groups be clearly charged with the responsibility of implementing the changes.

Progress reports from this Joint Education Committee must be presented to the annual general meeting of each of the membership organizations and to the **Minister of Health** each year for the next three years, beginning in 1992.

Recommendation 5

That the College establish a clear and ongoing liaison with the committee planning Education of Future Physicians of Ontario (EFPO) and the Council of Faculties of Medicine, to help facilitate the required changes in undergraduate medical education.

Recommendation 6

That the College, the Law Society of Upper Canada, and the Metro Action Committee on Violence against Women and Children (METRAC), together with representation from survivor advocacy groups and survivors, cooperate in developing a continuing education program geared to the effective investigation and prosecution of sexual abuse complaints against physicians and other health care providers, including training in appropriate treatment of child witnesses and vulnerable adult witnesses. Only lawyers who have completed this course should be eligible for selection as prosecutors of sexual abuse complaints at the College. (This recommendation is already in the planning stages by the College, the Law Society, and METRAC).

Recommendation 7

That the College, together with the Ontario Medical Association, the Ontario College of Family Physicians, the Ontario Psychiatric Associa-

tion and survivor and patient advocacy groups such as the Disabled Women's Network Canada, the Patients' Rights Association, and the Metro Action Committee on Violence Against Women and Children (METRAC), and representatives from the Ministries of Health, Education, and Community and Social Services develop an information brochure for patients. That this brochure contain the **Physician's Commitment to Patients**, the indicators of appropriate physical examinations, the list of warning signs and examples of sexually abusive behaviours contained in this Report, the options available for reporting and for help, and how to access the College, including the address, telephone numbers, and who to contact. That this brochure be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape. That the College require this brochure to be available in every location where physicians practise and require that it be provided by members to any patient who discloses sexual abuse by another doctor.

That the **Physician's Commitment to Patients** also be prepared in poster form, and include the right to appropriate medical examinations; the right to say "no;" the right to ask questions, the right to understand, to the best of the patient's ability, what is happening to his or her body during treatment; the right to report sexual abuse by a physician, and how to access the College.

That the College encourage and support in all ways possible the display of the **Physician's Commitment to Patients** poster in every location where physicians practise. That the College also encourage the display of the brochure and the poster at other health and treatment centres, schools, sexual assault care centres, health clubs, community centres, and public centres, and make them available to these centres.

Recommendation 8

That the College actively promote public awareness of its role, policies, and procedures, the **Zero Tolerance** standard, and the entire complaints and discipline process in as many ways as possible, beginning with production of a poster and a brochure. That these be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape. That the College, in cooperation with the **Ontario Hospital Association**, ensure the brochure is available in every location where physicians practise and encourage and reward the display of the poster there. That the College also encourage the display of the poster and brochure in the other locations in Recommendation 7 and make them available to these locations.

Recommendation 9

That the College initiate the establishment of a **Joint Committee on Medical-Psychotherapy** to review and recommend ways to ensure that physicians carrying out full-time or part-time psychotherapy have adequate training, particularly in the care of survivors of sexual abuse. Membership in this committee should include, at minimum, senior representatives of the College, the Ontario Psychiatric Association, the

Medical-Psychotherapeutic Institute of Ontario, and the Ontario College of Family Physicians, and the General Practice Psychotherapy Network. At minimum, the committee's recommendations need to address two issues:

1. How to ensure that physicians practising psychotherapy are adequately trained to treat sexual abuse survivors effectively, including training in appropriate boundary management.

2. How to prevent physicians who have lost their licences due to a finding of guilt related to sexual abuse from becoming unlicenced psychotherapists, with the potential to abuse patients again.

That the Committee issue preliminary recommendations and an implementation plan to the Evaluation Team proposed in Recommendation 1(a) and (c) by June 1992.

The message to physicians must be given in the context of helping physicians to provide as good care as possible to all patients, rather than being highly critical and hostile to physicians for manifesting attitudes that are pervasive in our society.

Educating physicians about long-term harmful consequences of sexual abuse is clearly an important step in eliminating this problem but this education must be given in many contexts and situations to accommodate differences in learning styles and educational opportunities, and must recognize the difficulty in changing long-held social attitudes.

Barbara Lent, M.A., M.D., C.C.F.P., Ontario Medical Association Committee on Wife Assault

Education for Physicians

As required by our Terms of Reference, the Task Force assessed the needs in educational initiatives for physicians. We have heard strong consensus among survivors, advocacy groups, medical educators and individual physicians that current education programmes for physicians are not adequate and that improvements in education will be a pivotal element in achieving needed change.

We have concluded that there are three broad needs in education for physicians:

- The need for improved recognition and treatment of sexual abuse, including sexual abuse by physicians.

- The need for substantive training in appropriate behaviours and interaction with patients, particularly appropriate treatment boundaries.

- The need for training to dispel troubling misperceptions held by physicians about sexual abuse.

We have also observed a tendency, when discussing educational initiatives, to gravitate towards training for students. We agree that such education is important. However, we note that approximately 600 medical students per year graduate in Ontario and we believe the focus of effort needs to be on achieving the training goals among the 26,000 physicians already practising in Ontario, since the need for change is urgent. The Medical-Psychotherapy Institute of Ontario has taken the lead to provide this needed education.

Detailed Findings

Difficulty for Survivors in Finding Effective Treatment

We heard many troubling reports from survivors of sexual abuse by physicians about the difficulties experienced when they looked for the treatment they needed to heal. For many survivors, the first hurdle was feeling ready to trust a caregiver again. Once they reached this point, many had difficulty finding someone willing to help with this particular kind of abuse and to give them the support, validation, and care they needed. Often, well-meaning physicians tried to help, but lacked the skills required, and the treatment was of little value. Survivors who had their memories of the abuse blocked (a common way the psyche defends itself from trauma) and presented with physical or emotional symptoms were often misdiagnosed because the underlying cause of sexual abuse was missed, and treatment was inappropriate or unhelpful.

One survivor's experience of trying to find help after she had been abused by a physician is as follows:

> A young woman saw a psychiatrist to treat her depression over a four-year period. Over time, she became extremely attached to him although she was wary of his angry moods which he exhibited at unexpected moments. For example, she remembered commenting once on how often he was looking at his watch, and he blew up. "You came to see me; I did not come to see you. You are a controller," he yelled at her. Soon after this incident, the psychiatrist got up, approached her, and began to play with her belt buckle. She felt extremely defenceless and powerless with his seductive behaviour. Three years into therapy, the psychiatrist began to verbally seduce her by using a combination of literary allusion, emotional expression, and extremely intimate comments. He made remarks such as, "Do you get wet with the primordial sea? Tell me your sexual fantasies about me." He pulled her to him, sat her on his lap and told her to stroke him. On two occasions he pressed his erected penis against her. After each incident, he would reject her; once telling her he would have to be working towards termination, another time telling her that she should come every two weeks instead of once a week.
>
> She continued the therapy, but it was extremely difficult. She cried a lot during sessions, was apologetic and threw her arms around him frequently. She began to feel that he was a serious threat to her previously good marriage. His callousness developed to the point where he didn't realize that it was her last appointment. He misspelled her name on a prescription for tranquillizers. When these events were pointed out to him, he replied, "I have done you a favour, I have released some pressure from your unconscious. You are just an unhappy person and you have to accept it."
>
> The woman became depressed for months after the termination and broke down entirely. She was unable to work, mother, or live a full life due to anxiety, depression and fits of crying that lasted all day, every day. Her physical health also became very precarious; she still has ringing in her

ear and some dizziness from a virus contracted at that time. She also lost twelve pounds which she has not been able to regain.

She submitted a formal complaint to the College, which is still under investigation.

She sought treatment from another psychiatrist. She discovered this psychiatrist had been a colleague of the abusing psychiatrist for twenty years. He admitted to her that he had never treated a patient who had been abused by a psychiatrist. The therapy did not work so she had to terminate. She decided to find a female psychiatrist. She was "hit with a wall of prejudice, cowardice and evasion." She got several names from female friends in the health care field, but when she called these female physicians, they avoided treating her. She was finally told outright that nobody wanted these cases, especially if there was a complaint under investigation. One "honest" practitioner told her, "If these problems arise during therapy, then you deal with them, but very few people are going to want to walk right into a difficult situation like that." She spent days on the phone opening up to complete strangers only to be given another phone number to try.

She eventually talked to a female psychologist who told her that her former psychiatrist's abusive nature was an open secret in the women's health community. She named women who had been "wired by his manipulation, mind games, sudden rages and destructive criticisms." The psychologist told her that women had been "torn apart and needed deprogramming."

This woman was finally able to find a woman psychiatrist to treat her, although she will have to wait five months for her first appointment.

The experiences of the survivors we met with are consistent with the literature. One U.S. study of adult incest survivors found that adult victims seeking help had seen, on the average, 3.5 professionals (including physicians) in their quest for help (the range was 1 to 9 professionals). In the long run, about 50% of these survivors found a lasting and "probably therapeutic" contact; the rest did not. The key problems appeared to be a preference by professionals to work on "here and now" issues instead, leaving the trauma from the childhood sexual abuse untouched, or the offering of instant advice and moral indignation, indicating a lack of real interest and true understanding of the survivor's complex feelings (Frenken and Van Stolk, 1990).

Another U.S. study of adult incest survivors found that 23% of the sample re-experienced sexual abuse in their therapy, under the guise of declarations by the therapist that he loved the patient or that the patient needed to experience sexual feelings again. A further 23% of the sample experienced other kinds of harm, such as being disbelieved by the therapist, being told they fantasized the events, having the impact of the incest discounted because no intercourse was involved, being blamed for the abuse, having drugs overprescribed, or experiencing a reaction of shock or disgust by the therapist (Armsworth, 1989).

These experiences are symptomatic of inadequacies in training for physicians and other health care providers in how to provide good care to survivors of sexual abuse, including survivors of sexual abuse by physicians.

Particular Problems in Psychotherapy

A great deal of psychotherapy, including long-term psychotherapy, is practised by physicians. Many patients deliberately seek out a physician-therapist due to the high cost of private therapists (generally $50-$100 per hour, or more). While some physician-therapists have sought training and supervision in psychotherapy, we have learned that many do not, and that the level of training and skill varies widely between individuals. It seems that many physicians believe that little or no special training is required to do psychotherapy. However, providing effective therapy requires a high level of skill and training, just as other medical specialities, such as surgery or paediatrics, do.

The lack of training is evident in the experiences of some of the survivors we heard from who had sought help from physician-therapists:

- Refusal on the part of the therapist to explain the processes, techniques, or goals of the psychotherapy.

- Demands by the therapist that his or her competence and effectiveness be accepted without explanation or scrutiny, or the creation by the therapist of an atmosphere in which questions felt unacceptable.

- Reactions by the therapist that trivialized or discredited the responses of the patient to the abuse.

- Lack of enforcement of appropriate treatment boundaries, including the creation of a sexualized atmosphere in the therapy or the lack of prohibition of sexual acting out by either patient or physician.

"It is a big mistake of psychiatric educators to have believed that ethical behaviour is simply a function of good common sense."

Dr. Paul Cameron, University of Ottawa, Faculty of Medicine, at a Task Force public hearing, March 1991.

One case that demonstrates how the therapist transgressed appropriate boundaries into abuse is as follows:

> A woman was seeking a female therapist who was covered by OHIP. She was only able to find a male physician who was covered by OHIP. She met the doctor and was intrigued by his approach. He was friendly, casual, and showed great interest in what she was saying. It had been a long time since anyone really listened to her. A few months into therapy, the doctor got up, walked behind her and put his hands on her breasts. She felt his erect penis against her back, but didn't mention it because she was afraid she would embarrass him. During another session, he only stopped when she told him that she was unable to talk while he did what he was doing. Another time, he asked her out for lunch, paid for it, and billed OHIP for the time. In one office session, he removed her brassiere and placed his hand on her breasts. He kissed her but she froze. He asked, "Do you think I get my jollies this way?" He called the next day to tell her that she had had the look of a rape victim on her face. At another session he stared into

her eyes and asked her if she had any response to him. She told him no, and he claimed that he was getting aroused. Another time, when he had her sit on his lap, he began to cry, and then told her that he felt closer to her than anyone else. He then kissed her, but she told him that he should really be doing this with his wife. He told her that he really loved her, and she believed him. After a while, he casually told her that he was in love with someone else from the therapy group and he then dropped her.

(Note: This was the fifth report to the Task Force about this doctor).

At minimum, the effect of inadequate training for physician-therapists means that healing for the patient does not occur. Much worse, therapy where the physician is untrained in boundary control or does not practise it is where some survivors experience their abuse, or are re-abused.

Lack of Training in Recognizing and Treating Sexual Abuse



Members of the public at one of the Task Force's public hearings in Toronto

Undergraduate medical training in recognizing the manifestations of sexual abuse and their treatment is currently very limited. Even in post-graduate psychiatric education, training in treatment of sexual abuse is woefully inadequate. Our surveys of medical schools indicate that little or nothing is taught in most postgraduate psychiatric programs about sexual abuse, women's issues, or managing gender in medical practice. (The University of Ottawa has begun some systematic teaching in this area. The University of British Columbia has eight hours, the University of Calgary a few hours, the University of Western Ontario one lecture on women's issues, the University of Toronto little or no time on these issues.) We suspect that these findings reflect inadequacies in all specialty training, but we have not had the resources to survey these programs thoroughly.

Yet, given the prevalence of sexual abuse in Canada, it is likely that every physician will be required to treat survivors of sexual abuse in his or her practice. The Badgley Committee, in its 1983 national study of over 2000 Canadian adults, found that about one third of males and just over one half of females reported that they had been the victim of at least one unwanted sexual act in their lifetime (Badgley Report, 1984, as quoted in The Report of the Special Advisor to the Minister of National Health and Welfare on Child Sexual Abuse in Canada, 1990).

Further, as outlined in Chapter 2, the health consequences of sexual abuse, including sexual abuse by physicians, are significant and numerous; emotional distress and mental illness, physical disease, family breakdown, and reduced capacity to work, to parent, and to thrive. Survivors of sexual abuse have higher than average incidences of many forms of physical and mental illness (Donald et al, 1990; Harrop-Griffiths et al, 1988). Survivors are also more frequent than average users of the health care system (Waigandt etal, 1990).

In the absence of training in the sequelae of sexual abuse, the physical and psychological symptoms are frequently misdiagnosed, leading to unnecessary investigations and inappropriate treatment. This is tragic for survivors since damage caused by the abuse is not treated, frustrating for physicians when prescribed treatments don't work or patients return again and again with vague complaints, and expensive and burdensome to the health care structure.

We also found that most physicians are not trained in how to facilitate disclosure of sexual abuse, or how to respond appropriately when it is disclosed. Yet an inappropriate response, such as disbelieving the disclosure, suggesting or implying that the victim must somehow have been responsible, or trivializing the impact of the abuse (common responses among those without training) can be devastating to the patient and set back the healing process significantly.

There is also very little training, if any, in the context in which sexual abuse occurs in our society, such as gender socialization, women's issues, the tolerance of violence against the less powerful in our society, and issues of gender, race, and class related to abuse. There is also limited training, if any, in differences between cultures in sexuality, sexual practices, and perceptions of sexual abuse.

These inadequacies leave physicians, including those with the best of intentions, poorly equipped to provide survivors of sexual abuse with the help they need. It seems that in the past, the emphasis in medical education has been on the purely biological factors in health and illness, at the expense of the psychological and social factors which influence health and patients' health-seeking behaviour. (For some discussion of how physicians can assist survivors of sexual abuse, see "Providing Assistance to Survivors of Sexual Abuse" in Chapter 4.)



Educational Round Table

Lack of Training in Appropriate Behaviours and Interactions with Patients

We heard throughout our consultations on education that there is currently very little training provided to physicians on interacting appropriately with patients, and that such training is necessary if we are going to deal effectively with sexual abuse of patients. There is a strong belief that such training may contribute to a reduction in some kinds of abuse.

The training that is needed includes:

- **Training on the power and dynamics in the physician-patient relationship, and how to set and enforce appropriate treatment boundaries with patients, particularly when treating survivors of sexual abuse.** It is important that physicians understand how the power the physician brings to the physician-patient relationship affects that relationship. It is also important that appropriate treatment boundaries are understood, and that physicians know how to set and enforce such boundaries with all patients.

  Appropriate treatment boundaries are based on the physician limiting his or her activities in the relationship to meeting the treatment needs of the patient. Treatment boundaries are violated when the physician's activities are based on meeting his or her own needs, or when the gratification for the physician comes directly from the patient, rather than from the process of treatment.

  Physicians need to be trained to expect that patients, particularly survivors of sexual abuse struggling to recover, may not know what boundaries are appropriate and may test those boundaries as a way of determining the physician's trustworthiness. They need to be equipped to recognize this testing and to set and enforce boundaries that are appropriate.

- **Training that builds the comfort and awareness of physicians with their own sexuality and human sexuality generally.** The time and content devoted to human sexuality in medical training is currently insufficient to equip physicians to discuss issues of sexuality comfortably and appropriately with their patients, and to feel comfortable with their own sexuality. One doctor who graduated just 10 years ago from a highly-regarded Ontario medical school described the training on human sexuality as one lecture with some films this doctor considered pornographic, including animals performing sexual acts.

- **Training on how to recognize signs in their own behaviour that they may be heading towards sexual abuse of patients, and what to do about it.** Some physicians told us that while their training may have included learning that sexual contact with patients was not acceptable, they were not trained in how to deal with feelings of attraction to patients. When this actually happened, then, they didn't know what to do.

  Treatment boundaries often erode gradually and imperceptibly with warning signs, that, if recognized, can be used by physician and patient to avoid abuse. Two key signals for physicians, based on experience with therapists, are that the physician is requesting or pressuring the patient to perform a task or join an activity for the primary benefit of the physician, or that the physician is asking to see the patient outside the office in the absence of an actual emergency or other compelling clinical reasons (Simon, 1989). (For more on warning signs, see "Warning Signs: Physician Behaviours that Indicate Potential for Sexual Abuse" later in this chapter.)

- **Training on how to perform examinations and touch patients in an appropriate manner.** In responding to our Preliminary Report, some

physicians questioned whether they were equipped to perform examinations or touch patients in ways that would not be considered abusive by the patient. We believe it is important that all physicians receive the training they feel they need to be confident in performing needed examinations and in providing caring, supportive, healing touch to patients.

Troubling Misperceptions by Physicians

Of particular concern to the Task Force is our finding that many physicians hold the same troubling attitudes and misperceptions about sexual abuse as untrained members of the public do. Yet physicians are likely to be sought out by patients looking for help and understanding in dealing with their abuse. Further, physicians can play an important role in influencing changes in attitudes by the public.

The troubling attitudes that we heard throughout our process include:

The tendency to blame victims for the abuse, rather than realizing that because the physician has more power in the relationship, it is always the physician's responsibility not to abuse, no matter what the circumstances;

Quote from a survivor of physician sexual abuse responding to comments by physicians made at our June 20 public hearing:

"Abuse is abuse, regardless of the reason the patient walked into the office."

> ***"The idea that the woman complainers interviewed by the Task Force never did anything to tempt male physicians is a bit far-fetched. Women normally coming in to see a male doctor put on their best clothes, their best shoes, decorate themselves up to make them look as attractive as possible."***
> *-A Toronto physician*

The tendency to believe that women and children lie about sexual abuse, instead of recognizing that most abuse is never reported, and that false reports, while not impossible, are rare;

> ***"I think every patient who has a sexual complaint must do so in writing or else she will change her statement like weather and not stand by it."***
> *-a physician from Newfoundland*

The belief that the patient is in a position to consent to the abuse, and that if she did so, sexual abuse did not take place;

> ***"Remember, it takes two to tango."***
> *-a retired physician, Toronto*

The belief that the sexual abuse was probably not that harmful, since physical force and violence may not have been present;

> ***"It is totally inappropriate to drive a man or woman physician from the source of their income from the rest of their lives based on a single incident of misbehaviour"***
> *- a Toronto physician*

The belief that reports of sexual abuse by patients must be due to misunderstandings by patients of procedures that are entirely appropriate.

> ***"Patients often misunderstand what is an appropriate or inappropriate examination and this is an area of considerable concern and one which can also be distorted, particularly in certain situations."***
> *-a physician professor of psychiatry*

The survivors we listened to did not "misunderstand" the treatment the physician provided. They knew immediately, by their feelings of violation and betrayal, that abuse had occurred. Sometimes, they also experienced a strong desire not to believe what had happened to them or looked for ways to rationalize what had happened, since this was easier to accept than the frightening truth of the abuse. It would be wrong, however, to assume that these defence mechanisms bear any resemblance to "misunderstanding."

Concerns About Abuse in Faculty-Student Relationships

We heard testimony that the problem of abuse of power and trust is not only present in physician-patient relationships, but also in relationships between medical faculty and their students.

One indicator of this problem is evidence of sexual harassment of students in medical school. A February 1991 study of year 1 and year 4 medical students at the University of Toronto found that 46% of the female students had experienced sexual harassment in the program as had 19% of the male students (Dr. R. Moscarello, University of Toronto, research in progress, May 1991). Research also confirms resident-educator sexual contact, and raises questions about the harm it causes. One Canadian study of psychiatric residents found 4.1% of the female residents and 1.2% of the male residents had sexual contact with their educators; 37.5% of the involved residents reported mixed feelings about it. The authors concluded more education on resident-educator sexual contact was needed (Carr et al, 1991).

Even more concerning, however, were reports that came to us that some prominent teachers of medicine - the role models for tomorrow's physicians - were in fact abusers of patients and students, and that attitudes of some faculty members and residency supervisors trivialized abuse, showed disrespect for treatment boundaries, or reflected limited understanding of power and trust issues.

One survivor, herself a psychoanalyst, talked of abuse in a professional relationship with her analyst and of the difficulty she had in approaching the College because of his professional standing.

Input on How Better Training for Physicians Can Be Achieved

Through our educational Round Tables and our Advisory Council, we canvassed medical educators and advocacy groups on how the needed changes in education for physicians can be achieved. We also received a

great deal of commentary on this issue in response to our Preliminary Report. We were encouraged by the strong commitment to change by these organizations and by individual physicians.

Key aspects of the process of achieving change in medical education appear to be:

- The need for the involvement of a broad spectrum of organizations and types of expertise in developing the specifics of changes in curriculum, teaching methodology, and accreditation, in order that all key needs are reflected and that solutions are practical and workable.

- The need for such education to occur at all levels of medical training, to be incorporated into core curriculum, and to be integrated throughout a range of subject areas.

- The need to employ a wide variety of formats, teaching methods, and approaches, in order to accommodate differences in learning styles among physicians and resources by region, and to ensure that all physicians are reached.

- The need to design and deliver programs so that those most in need of the information receive it.

Recommendations

We are recommending significant initiatives in education for physicians to address the three areas of need we have identified (see Recommendations 2 and 3). The key features of the recommendations are:

- Substantive additions to the existing medical curriculum, in a range of specific areas.

- The incorporation of these additions at all levels of physician training, including practising physicians.

- The inclusion of these additions in examinations and accreditation throughout training and practice.

These changes are recommended because:

- The training will give physicians the assistance they need to provide better care to their patients, particularly survivors of sexual abuse.

- It will help to ensure that sexual abuse by physicians does not occur out of ignorance on the part of physicians.

- It will help correct current misperceptions about sexual abuse held by physicians, facilitating not only better patient care but, we hope, shifts in public attitudes as well.

We are recommending that the training be part of examinations and accreditation because we judge it to be so very important to achieving change.

Education for the Public

In addition to assessing the needs in educational initiatives for physicians, we were also asked to assess needs in education for the public.

Key Findings

- Most patients are not "educated" in what constitutes good treatment by a physician. They go to the doctor when they need help, and are usually particularly vulnerable if what they are seeking is therapy. Most of the time they do not know what to expect in terms of examination or treatment - they trust the physician to know and to do the right things. Often, then, the only way they have of knowing whether the treatment was abusive is from their feelings after the abuse has taken place - feelings of violation and betrayal.

- Feelings of disempowerment on the part of the patient - due to the power of the physician, demands by the physician for blind acceptance of treatments or procedures by the patient, or the creation of an atmosphere in which questions could not be asked - often contributed to vulnerability to sexual abuse or delays in reporting abuse.

- Very often, warning signs that sexual abuse was imminent were present, in the form of small boundary violations or instances of inappropriate behaviour, but were not recognized by the patient. Patients (and physicians) need to be aware of these warning signs and the importance of trusting their own feelings of discomfort when they experience them. (See "Warning Signs: Physician Behaviours that Indicate Potential for Sexual Abuse" later in this chapter.)

- There appears to be little knowledge by the public of the existence of the College, its role as a protector of the public, or the existence of a complaints process. This is consistent with the findings of the College's 1990 Complaints Task Force. (As outlined in Chapter 2, there are also many members of the public who are aware of the College and perceive the complaints process to be biased in favour of physicians.) The lack of awareness likely means that many incidents of sexual abuse are never reported to the College, compromising the College's ability to remove abusers from the profession. It has also meant that many survivors have felt powerless; that they have felt they had no options, other than criminal action, for redress or for preventing the abuser from harming others.

Conclusions

The Task Force has concluded that there are some critical needs in education for the public. The key needs appear to be:

- Increases in knowledge about what behaviours, examinations, and treatment procedures are appropriate, and which are not.

- Increases in knowledge about what physician behaviours signal the potential for abuse, so that the situation can be dealt with before abuse occurs.

- The need for patients to feel an increased degree of power within the physician-patient relationship.

- Increases in awareness of the College, its role in protecting the public, and the existence of a complaints procedure, and how to access this resource.

These needs, if met, may prevent some incidents of sexual abuse by physicians and should lead to increases in reporting abuse to the College, facilitating the removal of abusers from the profession.

"The Physician's Commitment to Patients" Statement

The Task Force is proposing the development of a statement called "The Physician's Commitment to Patients", to be published within a larger information brochure and as a poster to be placed in physicians' offices and other centres associated with health. A draft of this statement is included at the end of this section.

We are recommending this because:

- It will help create a feeling among patients that they have some power within the physician-patient relationship. This should contribute to a lower incidence of abuse and an increased level of reporting when it does occur.

- It will help create a feeling that the physician's office is a "safe" place, because the physician's obligations are made explicit and clear. This is particularly important for survivors of past sexual abuse, including sexual abuse by physicians.

- It will provide a basis for discussion between physician and patient about the patient's right to be an active participant in the planning of his or her health care treatment. This will not only empower the patient, but is likely to result in increases in compliance with the treatment.

- The use of a poster as one of the formats will ensure quicker and broader awareness of the "Physician's Commitment to Patients" statement than if it were only available in brochure form. We believe that quick growth in awareness is a necessary part of the implementation of a **Zero Tolerance** philosophy.

DRAFT OF PHYSICIAN'S COMMITMENT TO PATIENTS

1. **I will act in your medical best interest at all times, with your knowledge and consent, and without discriminating according to culture, religion, race, language, disability or sexual preference.**

2. **I will never exploit the doctor-patient relationship for financial, sexual or personal purposes.**

3. **I will listen carefully and supportively to your physical, emotional or other concerns.**

4. **I will diagnose and treat your problems to the best of my knowledge and skill.**

5. **I will guard the confidentiality of any information I have about you, unless you give me your informed consent to disclose it, or I am required to disclose it, for your safety or the safety of others, by law or a court of law.**

6. **I will discuss the expectations and responsibilities that each of us brings to our relationship, and answer your questions as best I am able.**

7. **I will be on time for our appointment unless an unforeseen matter requires my attention urgently and I will make every effort to notify you in advance if I am unable to keep our appointment.**

8. **I will be sensitive to your right to dignity and respect when an examination requires that you remove some or all of your clothing.**

9. **I will perform diagnostic or therapeutic procedures only after I have explained them and obtained your informed consent, and I will be especially sensitive when performing procedures that may be awkward, painful or uncomfortable.**

10. **I will respect your right to refuse examinations or treatment, or to withdraw consent.**

11. **I will make a referral or consult with another health professional whenever you and I believe it is appropriate.**

12. **I will try to direct you to the appropriate professional or agency when I cannot help you.**

13. **I will keep my knowledge and skills up to date by reading, attending training sessions and other forms of continuing education.**

14. **I will listen to and try to remedy any complaints you may have about the quality of care given by me or my staff.**

15. **I will inform you about the role of the College of Physicians and Surgeons if I am unable to address your complaint in a way that satisfies you.**

An Information Brochure for Patients

We are also recommending the development of an information brochure containing the "Physician's Commitment to Patients" statement (and urging patients to look for it in physicians' offices), the warning signs of potential abuse, information on appropriate and inappropriate examinations and behaviours, options for reporting sexual abuse (criminal action, civil action, or complaint to the College), and how to contact the College. This brochure would be required to be given to all patients who disclose sexual abuse by a physician.

We are recommending this because better information for patients may help prevent some incidents of abuse and should lead to an increased level of reporting when abuse does occur, facilitating the removal of abusers from the profession.

Building Awareness and Understanding of the College

We are also recommending that the College actively promote awareness of its role, its policies, its procedures, the **Zero Tolerance** standard, and its complaints procedure, in order to ensure that survivors of physician sexual abuse know where and how to report their abuse.

Warning Signs: Physician Behaviours That Indicate Potential for Sexual Abuse

Like others who have studied sexual abuse by health care professionals, we have found that other inappropriate behaviours by the physician - signs that appropriate treatment boundaries are being crossed - often precede the sexual abuse itself. While sometimes subtle, these behaviours can be recognized by the patient because they make the patient feel uncomfortable, uneasy, or confused.

Several U.S. jurisdictions working to reduce sexual exploitation by therapists have developed lists of such warning signs in order to better educate patients (California Department of Consumer Affairs, 1990; Pelka, 1989).

Based on the cases that came to the Task Force, physician behaviours that indicate potential for sexual abuse include:

Signs of "special" treatment by the physician, such as:

- Physicians confiding in a patient about the doctor's personal problems with spouse or partners, instead of focusing on the patient's problems.
- Physicians doing therapy in social settings, such as over dinner.
- Physicians offering drinks before, during, or after the patient's appointment or examination.
- Physicians offering to drive a patient home and "see her in".

- Physicians giving a patient significant gifts.

- Physicians scheduling a patient so no one else (receptionist or other patient) is in the office at the time of the appointment.

- Physicians not charging or billing for therapy.

Signs of misuse of power or influence by the physician, such as:

- Physicians suggesting that they would be a better partner than the patient's spouse or partner.

- Physicians encouraging a patient to leave a spouse, using threats of termination of treatment to do so.

- Physicians splitting a family by identifying some members as "crazy" or having no credibility.

Signs that the physician is sexualizing the atmosphere, such as:

- Physicians being preoccupied with sexual talk, except where the patient's explicit purpose in seeking the consultation or treatment was to discuss sexual issues.

- Physicians using sexual remarks to praise a patient, eg. "you look sexy today" or "you have beautiful eyes".

- Physicians inquiring about a patient's likes and dislikes in sexual activities, except where clinically indicated by the type of consultation.

Surprisingly, these warning signs are not part of current training for physicians, nor do most members of the public appear to be aware of them.

When these behaviours appear, physicians should seek assistance from peers or professionals with expertise in sexual abuse. Patients should question their physicians about these behaviours, discuss the situation with a professional with experience in sexual abuse, or seek treatment from another physician.

We believe that improved awareness of these warning signs, and how to respond to them, can play an important role in reducing the incidence of physician sexual abuse.

Education for the College

We are recommending substantive training for every individual at the College who may have contact with someone inquiring or complaining about sexual abuse, as well as for all College Council members.

This recommendation is based on interviews with College Council members and staff, complainants to the College, and survivors who had contacted the College but did not proceed with a complaint.

We also looked in detail at the telephone inquiry process to identify systemic barriers to accessing the College system. By early May 1991, we were assured by the College that any problems with the telephone inquiry process had been addressed. Without notifying the College, we then commissioned an independent test to verify the extent of the change. The test was conducted by therapists who have worked with survivors of physician sexual abuse, who posed as survivors inquiring about laying a complaint; they did not make formal complaints or leave false reports with the College. Their expertise was invaluable in providing us with an independent assessment of the system and ensured that they could conduct the test from the perspective of a survivor.

Findings on Training

We found that there has been no substantive training for College staff or Council members on sexual abuse or sexual abuse by physicians. A few individuals have gathered some limited information on their own and there is a greater willingness to learn than there once was. However, most College staff and Council members dealing with sexual abuse complaints are still operating from the same base of knowledge as the rest of the public on this issue including the same lack of understanding of sexual abuse involving a breach of trust and the same misperceptions and attitudes.

Findings on the Telephone Inquiry Process

What the Process Used to Be

In the past, there were significant obstacles in place for callers who wanted to report sexual abuse by their physician. For example, it was policy to explain to a reporting patient that if the College only had her word against the physician's, the case would not be strong enough to proceed. Some patients were told that the complaint would not be acted upon unless there was a second complaint against the same physician. This was experienced by survivors as the College saying "You don't count". Even worse, the first patient's name and report were not usually kept, so there was no way to match the report to the report of a second patient who called. A survivor who called the College was told that there were no other complaints against the doctor. As she says:

> ***"By not investigating the first complaint about a doctor, the CPSO is giving physicians permission to abuse one patient each."***
> - Jean Halliwell, Public Hearing, Windsor

Some patients were told that the physician they were complaining about had a "perfect record"; this was a powerful way of invalidating the patient and stopping the complaint. Patients were also told that they had to provide the complaint in writing or "nothing could be done"; this disregarded the difficulty many survivors have, due to their trauma over the abuse or a lack of strong writing skills, in putting what happened into writing.

Sometimes the patient was given the opportunity to speak to an Investigator or an Inspector to determine whether she wanted to begin a complaint. Little explanation was given regarding the process. Complainants had little idea of what they were involving themselves in, including the College showing the physician the patient's letter of complaint. Many survivors fear reprisals by the physician. Callers were usually not told that once a complaint was started, it could not be withdrawn, even if they began to find the process traumatizing. (In practical terms, however, sexual abuse complaints did not proceed without evidence from the patient.)

Recent Changes in the Telephone Process

If the patient specifically identifies that she is calling about sexual abuse, her call is now referred to an Investigator or Patient Representative who works regularly on sexual abuse complaints, if one is available. Currently, these individuals are all women. They answer questions and will provide assistance in preparing the written complaint. Their response has been described to us in most instances as "friendly" and "open to answering questions".

If the patient does not specifically identify the purpose of the call as sexual abuse, however, or if the sexual abuse Investigators or Patient Representative are not available, the caller is asked to call back or simply told that the complaint must be in writing, that it should include "all the facts relevant to the complaint" (which may not be explained), and that the letter is sent to the doctor. She is also given the College address.

The changes to the system are encouraging. Yet systemic barriers to accessing the system still exist. The system continues to reflect a lack of understanding of what it is like to make that College contact from the survivor's point of view. Our independent testing indicated that callers may be put on hold for long periods of time, or be told they'll need to call again - enough difficulty to deter a survivor from proceeding. Callers are not consistently asked what help, if any, they need to make the complaint, if they have supports in place, or if they have questions. The system does not acknowledge the survivor who does not specifically identify herself as such. Nor does it recognize that it is common for survivors to "test" the trustworthiness of the system before actually reporting by calling to inquire about how to complain about wrongful billing, saying they are calling for someone else, or not disclosing all the details of their complaint in the first call.

The full complaints and discipline process is still not being explained to patients, unless they ask specifically about it. Therefore, they may still end up initiating the process before they are ready for the emotional demands it makes on them.

The results of our independent test were consistent with reports we have had from survivors who have contacted the College since the changes in the system were made.

Conclusions

There needs to be a much better understanding of sexual abuse by all College staff who may be involved in any way with sexual abuse survivors, and by all Council members, if the philosophy of **Zero Tolerance** is truly to be implemented and the system made fully accessible. The telephone inquiry system needs to be even more sensitive to the emotions and needs of the survivors when they call, including the likelihood that sexual abuse may not be explicitly disclosed every time. Finally, there is need for a full explanation of the complaints and discipline process to potential complainants before they initiate the complaint.

Recommendations

We are recommending substantive, ongoing training for all College Council members and any College staff who may have contact with those inquiring or complaining about sexual abuse. This training must address the common tendency to blame the victim, and include:

- The nature of sexual abuse by physicians, the consequences to victims, and issues of gender, race, and class related to abuse.

- The range of ways a survivor may initiate disclosure or inquiry, and how to handle inquiries, disclosure, complaints, and information dissemination in an appropriate, supportive, and empathetic manner.

- How to fully and appropriately explain the complaints and discipline process of the College to potential complainants, as well as the options a complainant has to launch a complaint through the criminal and civil justice systems (Recommendation 27).

This training is fundamental to achieving the needed changes in policies, practices, and procedures at the College. It will also be instrumental in the College's ability to fully implement the philosophy of **Zero Tolerance.**

Education for Prosecutors

The Task Force has found that prosecutors of sexual abuse complaints for the College, like most lawyers, have also had no substantive training in sexual abuse. Therefore, like the College, they are operating from the same general state of knowledge about sexual abuse as the public - with all its inadequacies - including the tendency to focus on blaming the victim rather than examining the responsibility and accountability of the perpetrator. For prosecutors, this has had significant impact on the evidence led (or not led) at hearings, the use of expert witnesses, the substance of cross-examination, and the perspective brought to the case.

We are therefore recommending substantive training for prosecutors (Recommendation 6). Such training - in the nature of sexual abuse by

physicians, the reactions by victims, issues of gender, race, and class bias related to abuse, and current knowledge about rehabilitation and the behaviours of physicians who sexually abuse - will result in more effective prosecutions on behalf of the College and better chances that decisions will be upheld on appeal.

Joint Ventures

We are recommending that many of the educational initiatives be accomplished by a series of innovative joint ventures, including:

- **A Joint Education Committee on Sexual Abuse**, to develop and implement the necessary changes in physician education (Recommendation 4).

- A liaison between the College, the committee Planning Education for Future Physicians of Ontario (EFPO), and the Council of Faculties of Medicine of Ontario, to facilitate the changes in undergraduate medical education (Recommendation 5).

- A cooperative effort by the College, the Law Society of Upper Canada, METRAC, advocacy groups, and survivors to develop and implement an education programme for prosecutors of sexual abuse cases at the College (Recommendation 6).

- **A Joint Committee on Medical-Psychotherapy** to recommend how to ensure physician-therapists are adequately trained and how to prevent physicians found guilty of sexual abuse by the College from becoming unlicensed therapists (Recommendation 9).

Joint ventures are recommended because the initiatives we have recommended are beyond the scope and mandate of the College alone. Joint ventures will gather the range of perspectives and expertise needed to implement the desired changes. They will lead to more thorough understanding of the issues involved than if the College were to act alone or with only a small group of experts. Joint ventures will ensure efficient use of resources through the synergy they create between the organizations and the avoidance of working at cross-purposes.

Our Preliminary Report recommended that training be required for those practising psychotherapy. We received substantial feedback that this issue was complex and required in-depth study. Based on this feedback, we have revised our recommendation to refer the two key issues that must be addressed to a committee for needed study and recommendations (Recommendation 47).

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CHAPTER 4

GUIDELINES FOR DOCTORS

In this chapter we suggest how physicians can assist patients who have been sexually abused, as well as the specific thinking behind the following recommendations:

Recommendation 10

That the College issue a guideline, effective immediately, that a physician should not have sexual contact with a former patient for a period of **two years** following the date of the last professional contact with the patient, even if the physician has formally terminated the professional relationship.

"In a way, as someone first learns about such a thing, his or her response is analogous to the emotional upset one experiences when finding out a loved one is a rapist or discovering incest in one's family."

Quote from a survivor of physician sexual abuse, from the written brief she prepared for her private hearing.

Recommendation 11

That the College issue a guideline, effective immediately, that, when the physician-patient relationship has been primarily for the purpose of **psychotherapy**, sexual contact with the patient is prohibited during the professional relationship and at **any time thereafter**, due to the lasting nature of transference and the power imbalance, and hence the potential for abuse created.

Recommendation 12

That in addition to immediately adopting and issuing the guidelines for doctors proposed by this Task Force, the College establish a **Guidelines Committee** to examine models from other jurisdictions and determine whether statutory changes would be more effective. That this committee include representation from the College and the Advisory Council to this Task Force, the Ontario Medical Association (including the Women's Issues Committee), the Ontario Psychiatric Association (including the Women's Issues Section), and at least two representatives of survivor advocacy organizations with demonstrated expertise in the area of physician-patient sexual abuse.

Recommendation 13

That if the information was obtained in the course of a physician-patient relationship where the patient is a physician, and the treating physician is satisfied that the patient has limited or withdrawn from practice to the extent required to eliminate risk of harm to other patients, the report to the College include a notation that the physician is in treatment and has agreed to limit practice appropriately and that the treating physician be required to notify the College when the physician-patient leaves treatment.

Recommendation 14

That the College re-issue its guideline that physicians should make a third party readily available to their patients at all times during internal examinations if the patient so wishes, that it be incumbent on the physician to inform the patient of the option to have a third party present, and that this precaution is essential regardless of physician/patient gender.

Recommendation 15

That the College issue a guideline immediately and that the **Regulated Health Professions Code** be amended so that it is **mandatory** that a member of the College notify the College in writing when he or she has reason to believe that another member of the College is or has been engaged in sexual impropriety or sexual violation, as defined in Recommendation 24, and that such information be recorded and retained by the College. A member who knows the name of the offender, even though the patient has not explicitly named the offender, is obligated to report the offender's name, but not the patient's name, unless the patient specifically so agrees in writing.

Recommendation 26

That the College identify in Regulations to the Act examples of sexually abusive behaviours in the two-tiered offence and ensure that these behaviours are known and understood by the physicians of Ontario.

Behaviours considered Sexual Impropriety or Sexual Violation (see Recommendation 24) include, but are not limited to:

- Watching a patient dress or undress, instead of providing privacy for disrobing.
- Deliberately making sexual comments about a patient's body or underclothing.
- Making sexualized or sexually-demeaning comments to a patient.
- Criticism of the patient's sexual orientation or preference.
- Making comments about potential sexual performance during an examination or consultation, except clinical comments where the patient's purpose in seeking the consultation was to discuss sexual issues.
- Making a request to date.
- Subjecting a patient to an examination in the presence of medical students or other parties without the explicit consent of the patient.
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation or presenting problem.
- Initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physician.
- All contact with genitals without the use of gloves.

Guidelines on Involvement with Former Patients

As required by our Terms of Reference, the Task Force is recommending specific guidelines on sexual involvement by physicians with former patients. We are not recommending that there be statutory amendments to institute these guidelines at the present time. However, it is imperative that the Guidelines Committee in Recommendation 12 be established to do further research, including whether American Statutory Guidelines effectively meet the standard of **Zero Tolerance**. The Task Force is convinced that a clearly-defined margin of safety would benefit patients and doctors. As with other guidelines issued by the College, a doctor is not obligated to follow them. If left only as guidelines, a doctor's decision to ignore the time restrictions would have only limited impact on the Discipline Committee's determination of whether the doctor was in violation of the act or regulations. The Task Force makes this recommendation because we believe that, at the present time, it is imperative that the College take a "first step" in bringing about a shift in attitude within the medical profession. The establishment of the Committee in Recommendation 12 should ensure that the goal of protecting patients continues to guide the College and the government in determining whether statutory or regulatory amendments which codify the guidelines and therefore make them a basis for a determination as to guilt are necessary. If only established as guidelines, then a doctor's decision to ignore the guidelines might be admissible as evidence as to what is "accepted professional conduct," but only if the College and the medical profession at large are seen as adopting the guidelines and abiding by them.



Input was sought from a number of multicultural women's groups, including the Coalition of Visible Minority and Immigrant Women

The Need for Guidelines on Involvement with Former Patients

Termination of the physician-patient relationship has often been used by a physician intent on sexually abusing to gain sexual access to patients or to rationalize the exploitation.

The Task Force heard a number of troubling reports of abuse from patients whose physicians had ended the physician-patient relationship in order to start or continue a sexual relationship with them. In some cases, physicians initiated the sexual activity during the time that the patient was in treatment with them and terminated the medical relationship in order to function as sexual partner. Others became interested in sexual involvement with their patient, transferred the care of the patient to another professional, and immediately began the sexual relationship. Some planned sexual involvement with the patient during the period of treatment and got in touch with the patient at some time after the treatment terminated, stating the involvement was not illegal or unethical then, as the treatment was over. In most of these cases, the patient was led to believe that the physician genuinely cared for her, only to come to realize later that she was in fact being exploited to meet his needs. Sometimes she also learned that she was not the only former patient so in-

volved. These experiences are similar to situations we have heard about in other jurisdictions.

One example of the reports of this kind that came to the Task Force is as follows:

> "I was 17 when my psychiatrist had sex with me for the first time. I was a virgin. He was 28 years older than me, twice married, and the father of 5 children. Our relationship lasted 1-1/2 years, during which time I became very confused and depressed about my part in all of this, resulting in several suicide attempts. Eventually, I was hospitalized after overdosing on medication, shortly after the doctor terminated our relationship completely. A few months earlier, he referred me to a colleague of his because he felt he could no longer continue seeing me professionally. Meanwhile, he continued sleeping with me. I was very hostile and uncooperative in therapy with anyone else, especially male therapists. I made no progress with the other psychiatrist, and stopped seeing him after the last suicide attempt. It was many years in and out of therapy before I could trust anyone again.
>
> It was also 10 long years before I felt strong enough emotionally to make a complaint to the College with respect to the actions of this man. Two years later, after some bureaucratic delay and financial expense (for me), he was found guilty of professional misconduct. He appealed and subsequently lost his licence to practise medicine in the province of Ontario.
>
> Because of this relationship, my life will never be the same. And I cannot begin to put into words the pain this man brought me and my family. I can only hope that by sharing my story with you that I can bring about some good from all of this."

"Transference exists in all doctor-patient relationships. There is a fantasy that there is only one woman right for one man in the universe. We have to let go of that, as doctors, and realize that patients are simply not potential romantic partners."

Dr. Gail Robinson, Psychiatrist, Co-Head of Women's Mental Health Department of Psychiatry, University of Toronto

The Council on Ethical and Judicial Affairs of The American Medical Association recognized the possibility for harm caused by physician sexual contact with former patients when it concluded in 1990 that:

> "Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship."

Based on the reality of these kinds of experiences, the Task Force believes that guidelines on sexual involvement with former patients are indeed necessary.

Key Principles

We believe that the point at which a sexual relationship with a former patient becomes appropriate is the point at which the relationship is no longer one of unequal power. Without equality in power, there cannot be the meaningful consent required for the relationship to be healthy.

The achievement of this equality does not begin the moment the professional relationship is terminated. The time to achieve this will vary from relationship to relationship, depending on factors such as the length of the

former professional relationship, the extent to which the patient has confided personal, private, or intimate information to the physician, the nature of the patient's medical problem, the degree of the patient's emotional dependence on the physician, and the degree of general knowledge the physician has about the patient's family situation (American Medical Association, 1990).

Secondly, the Task Force believes that physicians must enter medicine with an acceptance that they cannot consider their patients a source of potential sexual partners. This principle does not preclude a physician from finding a meaningful, satisfying relationship. It simply means that the physician must look outside his or her practice for such a relationship.

Many physicians and members of the public support this principle as being the natural result of the commitment a physician makes to work in the interests of the well-being of his or her patients and to be rewarded by that unique role.

Some people, particularly physicians, have questioned the Task Force on the fairness of this principle when applied to the situation of the small-town physician. There are concerns that it is more difficult to find a romantic partner in a small town and that the recommended guidelines will make it difficult to recruit young physicians for small towns. We believe, however, that the nature of the physician-patient relationship, and the differential in power within it that provides the potential to abuse, does not differ between the "big city" and "small town" situations; therefore, the same guiding principle must apply to both situations.

At a workshop conducted by the College in November 1990, participating doctors also reached the same conclusion by examining the patient's perspective. They concluded that allowing romantic involvement was unfair to the patient, as the awkwardness caused to both patient and physician when they became romantically involved significantly reduced the access of the patient to medical care in smaller communities.

Small town doctors reported to us that they have dealt successfully with this issue by committing themselves to dating only those outside their practice, whether within their own small towns or in nearby towns.

The General Guideline:

A Two-Year Time Lapse for Most Relationships

The Task Force is recommending a two-year time lapse after the last professional contact before sexual involvement with a patient is appropriate, unless the physician-patient relationship had been primarily for psychotherapy (Recommendation 10).

We are recommending a two-year time lapse as the general rule for several reasons:

- We prefer a specific time period as the basis for the guideline because of the clarity it provides for both physician and patient. While the nature

of the relationship remaining between them is in fact the key criteria, it is precisely the difficulty of making such an assessment, particularly on the part of the patient, that can lead to the exploitation. We believe the use of this reasonably determined time period to be most effective in preventing involvement that is damaging.

- The two-year period is based on successful experience with therapists in Minnesota, where a two-year prohibition has been the law since 1989. Their experience has indicated that the two-year lapse is effective in eliminating relationships that are damaging. They have found that 60 to 80% of damaging relationships are begun within 6 months of termination, close to 98% within one year, and the remaining within two years (Gary Schoener, Ph.D., Director, Walk-In Counselling Centre, Minneapolis, personal communication, March 1991). We are recommending the two-year period, as they did, to provide a margin of safety for patients. We believe this is appropriate given the serious harm caused by sexual abuse.

- We have concluded that the two-year time period is reasonable even if the physician-patient relationship is a transient one. A number of physicians, in responding to our Preliminary Report, expressed concerns about this guideline applying to one-time or infrequent physician-patient contact, such as a one-time treatment in an emergency room or a one-time contact to treat an ingrown toenail, on the basis that these sorts of contacts did not establish a significant physician-patient relationship.

The Task Force, however, heard two reports of sexual abuse that arose from just such one-time contacts in an emergency room, where the physician used his status as a doctor, and the trust his patient placed in him, to sexually abuse. In one of the situations:

> The patient was a woman experiencing difficulties with drug and alcohol abuse. She was brought to Emergency one night by friends, following a long "binge" of drinking. She was seen by the resident on call that night who recommended she see the staff psychiatrist at the hospital the next day. He also prescribed some medication for her to help her sleep. The resident asked her how she was getting home. When she said by taxi, he offered to drive her. She felt this was very kind of him, and accepted. When they arrived at her home, he seemed reluctant to leave, although it was very late. She sensed he was expecting to be invited in, so she asked him if he'd like some coffee before he left. He said yes.
>
> The patient and the doctor had their coffee. He called home to say he was tied up with a patient but would be home soon. He told the patient that she should take her medicine, and that he would check that the medicine was working and see she got to bed before he left. Once she was in bed, he climbed in beside her and raped her. The patient remembers feeling shocked at what was happening and powerless to stop it. She also remembers feeling that "he knew exactly what he was doing, and had done it before."
>
> Five months later, the patient found that she was pregnant. When the patient's son was about four years old, a policeman-friend asked her who the child's father was. She told him what had happened, and was

shocked to have the policeman tell her that the same physician had been investigated for sexual abuse involving two 15-year-old mentally-retarded girls, one of whom had been impregnated. Due to the incapacity of the witnesses, however, the police had not been able to make a case sufficient to convict the doctor.

The patient's abuse occurred 18 years ago. She understands that the doctor is still practising.

Reports like these have convinced us that the two-year guideline needs to be applied to all physician-patient relationships, if we are going to protect the public from abuse and achieve a **Zero Tolerance** position.

A Complete Prohibition Where the Relationship is Psychotherapeutic

We are recommending a separate guideline for situations in which the purpose of the former physician-patient relationship was primarily for psychotherapy. In these cases, we recommend that the guideline be that sexual involvement is not appropriate at any time after termination (Recommendation 11).

For the purposes of this recommendation, our definition of psychotherapy is not based on the definition used in the OHIP billing code, which covers a variety of types of counselling often performed by family physicians in the course of their work. Rather, the Task Force has defined psychotherapy as follows:

> **Psychotherapy:** An attempt to change behaviour, thinking or feelings by verbal means by a competent practitioner. Psychotherapy in this sense forms part of a therapeutic relationship between the client and practitioner. This relationship is based on belief, hope, and trust.

The relationship between psychotherapist/physician and patient is one in which the patient is particularly vulnerable to abuse. The dynamics of that relationship, due to the powerful impact of transference and countertransference, resemble the parent-child relationship. The Task Force has defined transference as follows:

> **Transference:** Positive or negative feelings the patient has towards the therapist which derive from earlier emotional relationships with other figures which can be transferred towards the therapist. These feelings originate from the earliest infantile experiences connected with parents, siblings, etc. These feelings may also be associated with the more recent past. The transference situation may be strongly positive and from the patient's standpoint represents falling in love with the therapist.

Transference leaves the physician in a position of great power. Experiencing sexual feelings on the part of either patient or physician-therapist may be a "normal" outcome of the psychotherapeutic process, both during and after the therapy. This creates opportunities for abuse unless appropriate treatment boundaries are set and kept clear. Research has shown that patients continue to experience very strong feelings for their therapist even 5-10 years after the therapy has ended (American Medical Association, 1990).

Due to the extremely powerful and lasting nature of transference, we believe that the relationship between physician and patient can never become one of equals, and therefore sexual contact is never without strong potential for exploitation.

This position is widely supported by professionals in the field of psychotherapy:

"I have written a chapter in my book on sexual exploitation in which I list a number of reasons for a lifetime ban.

Number one: Every study that has been done on transference indicates that transference persists. It does not end at termination of therapy. It is unique with the patient, and two years after termination, five years after termination the studies indicate that transference is instantly re-established. The same old feelings come back.

Number two: In studies that have been done on follow-up, something like two-thirds or 70% of patients return to their therapists...people return. If a parent dies, if they get a divorce, they go back to the therapist.

Number three: ...if there is not a ban on post-termination patient/therapist sex, then the whole character of therapy will be changed. If a patient came to me and she thought I was single and she was single and she felt she might date me sometime, she might decide not to talk about her sexual problems. She might want to make a real good impression. She might not want to talk about anything, thinking 'well, I want to impress this guy so that maybe he'll want to go out with me.'

Also, the very essence of therapy is the idea of giving up longings for old objects that you can't have. There has to be a mourning process, a grief process. I think this would be entirely bypassed if there was a possibility of a post termination relationship."

- Dr. G. Gabbard, author of Sexual Exploitation in Professional Relationships (American Psychiatric Press) From speech given in Toronto, September 11, 1991.

"The origin of any feelings of attraction between a therapist and former patient lies withing the psychotherapeutic relationship. The possibility that such an attraction may be acted upon, therefore, cannot help but distort the therapy. The therapy should focus on the patient's problems rather than function as a dating service for the participants. Given the power differential that exists in the doctor-patient relationship and the timelessness of unconscious processes, it is difficult to imagine how a decision to be sexually involved, even after termination, can ever be truly free and equitable. If the analogy to incest is accurate, post-termination involvement with a patient is no more acceptable that a father-daughter sexual relationship beginning one year after she has left home."

Dr. Gail Robinson, Co-Head, Women's Mental Health Department of Psychiatry, University of Toronto, (Written communication to Task Force, 1991)

The Guidelines Committee

The Task Force is recommending that these recommendations be implemented as guidelines issued by the College, rather than incorporating them into the Regulations to the **Health Disciplines Act**. This means that discretion in following the guidelines will be left in the hands of individual physicians.

We believe that this is an appropriate first step in dealing with this controversial area. We are left with some concern, however, that guidelines

alone may not be the most effective means of ensuring protection of the public. We believe there needs to be a more in-depth review of models in other jurisdictions to determine if further steps are needed.

Therefore, we are recommending the establishment of a **Guidelines Committee** to perform this review and to determine if changes to the Regulations to the **Health Disciplines Act** (or its successor) or changes to the statute itself are needed. The recommended make-up of the Committee is intended to ensure a variety of important perspectives and appropriate expertise is used in making this determination.

Reporting

The Need for an Improved Reporting Mechanism

We were asked to look at guidelines for physicians for reporting a patient's allegation of sexual abuse against another physician. Therefore, we reviewed the College's current practices on reporting. We also listened to physicians and other health care professionals who had reported or tried to report to the College, and to patients who had reported. Because the College was in the process of making changes to the information intake process, we also included a test of the ability of a health care professional to report abuse on behalf of a patient in the independent test we commissioned of the College's telephone inquiry system (see "Education for the College", Chapter 3, for information on this test. We did not leave false reports of abuse with the College).

Our key findings were:

- There is currently no formal procedure at the College for acceptance of reports of sexual abuse from third parties whether physicians or others, and until recently, such reports were usually not accepted. They are now accepted but must include a statement from the patient (Independent test, 1991).

- It is not unusual for physicians, other individuals and institutions to have knowledge that physicians are abusing and to do nothing with that knowledge. We heard many reports from patients who reported their abuse by a physician to another physician on the understanding that the physician would take some kind of action, only to learn later that he or she had done nothing. This led to feelings of betrayal and abandonment. It also led to beliefs that "all doctors protect their own."

- Often, well-meaning physicians had tried to report allegations of abuse to the College, only to be told that the information would not be accepted unless the patient would launch a formal complaint. The College held to this position even if the doctor explained that the patient was not yet ready to make a formal complaint.

- Other individuals who had tried to report had often met with the same obstacles.

These practices are an example of how a system implicitly tolerates sexual abuse. The result of these practices is that information relevant to protecting the public from physicians who are sexually abusing is being lost. As well, the College is losing access to a valuable source of corroborating information that could be used in investigating patient complaints of sexual abuse.

The Task Force has concluded that there needs to be an improved mechanism for reporting sexual abuse of patients by third parties, including doctors.

A New System of Mandatory and Third-Party Reporting: How it Works

We are recommending the initiation of mandatory reporting by physicians of physician sexual abuse and the establishment by the College of a firm policy of acceptance of third-party reports of such abuse (Recommendations 15-19). Our approach is based on the model currently in use for therapists in Minnesota, and is similar to existing Canadian requirements for reporting child abuse.

We heard substantial support for mandatory reporting from physicians and others throughout our hearings.

The system we are recommending works as follows:

- All physicians would be obliged to report any knowledge or reports of sexual abuse by another physician to the College.

- Reports by third parties other than physicians could also be filed and the information would be recorded and retained by the College.

- Such reports would include the reporter's name and a means of future contact and the alleged offender's name. The patient's name would be included only if the patient so agreed in writing, so that the patient retained the option of deciding when a formal complaint, and hence investigation, would be initiated.

- The acceptance of a report by the College would not trigger an investigation, unless a patient initiated a formal complaint.

- When the College had received more than one such report about the same physician, it would trigger a review of the evidence and the College would then determine whether it would start an investigation.

- Anyone who reported in good faith and on reasonable grounds would be immune from civil liability for making the report.

- The information contained in these reports would not be releasable by the College to anyone.

We are recommending this system because it is a necessary component in achieving **Zero Tolerance**. It makes sense for these reasons:

- Mandatory and third-party reporting recognizes the seriousness of the harm caused by physician sexual abuse in the same way that mandatory reporting of child abuse recognizes the seriousness of its consequences.

- The system ensures that knowledge of sexual abuse reaches the College and remains accessible to it. This will assist the College in fulfilling its mandate of protecting the public.

- The obligation on the Registrar to review the evidence and determine whether an investigation is warranted based on two reports recognizes the reality that it often takes some time for those who have been abused to come forward, and that in the meantime a physician who is abusing puts other patients at risk.

- The system addresses concerns by those who treat survivors of sexual abuse that mandatory reporting forces the survivor to be involved in a complaint before she is ready to handle the process or that it disempowers her by taking the decision of whether the abuse will be reported away from her. The absence of the patient's name from the report ensures that he or she is not forced to participate in the process before being ready. However, should an investigation against the same physician be initiated for other reasons, the College is able to contact the patient through the reporter, to inform him or her that another investigation is under way, and to see if he or she may be able to assist in the investigation or may now be ready to make a formal complaint.



Presenters from the Clark Institute of Psychiatry at the public hearing following release of the Preliminary Report

Our Preliminary Report included a recommendation providing an exemption from reporting to a physician who learned of the abuse by treating a physician who disclosed it, if the physician-patient had withdrawn from practice to the extent required by his impairment. We received substantial feedback that this recommendation was not consistent with **Zero Tolerance** or the state of knowledge about serial offending or rehabilitation. The treating physician was also seen to have no control over whether the physician-patient had really withdrawn from practice to the extent required to prevent **risk of harm** to the public.

Based on this feedback, we have withdrawn this recommendation.

When a physician or other individual reports to the College, he or she should keep a record of the report. The College should keep a record of all the information provided in such a way that the information can be cross-checked against other reports and that the reporter can be contacted again if there are additional reports of abuse by the same physician or if clarification is needed.

Safeguards for Doctors

A significant number of physicians and defence lawyers who responded to the Preliminary Report expressed concerns that the particular mandatory and third-party reporting system we are recommending could result in an investigation and conviction of a physician for sexually abusing based on an "anonymous report" and that it would be impossible to defend oneself under such a system. A legislative precedent is already established in Section 32(4)(5) of the Pay Equity Act, 1987. The Pay Equity Commission takes and investigates not only those complaints where the person gives a name and expresses a wish for anonymity, but also those complaints where the person never gives a name at all.

Many were also concerned that such a system would accept, if not encourage, malicious reports by disgruntled patients, colleagues, or other individuals. This is not the case.

As outlined above, the system requires that mandatory and third-party reports be made in good faith and on reasonable grounds. No investigation, and hence no hearing, will be commenced until there is either a written complaint by a patient or sufficient evidence brought to the Registrar that he or she, with the approval of the Executive Committee, requests that an investigation be initiated under Section 64 of the **Health Disciplines Act** consistent with existing safeguards.

The establishment of the reporting to the College rather than to some kind of provincial registry is also designed as a safeguard for doctors. It should provide for greater confidentiality of information than a provincial registry. **The information reported through this mechanism to the College will not be releasable to anyone.**

Reporting of Past Disciplinary Action, Civil Suits and Criminal Charges

As a further safeguard to ensure that the College can protect the public from abusers, we are also recommending:

- That physicians continue to be obliged to report to the College, as a condition of licensure or re-licensure, any criminal charges or convictions against them, and be obliged to report the initiation of any civil suits against them that involve alleged sexual impropriety or sexual violation, and that the College check previous licensing bodies of the applicant physician for such charges or convictions prior to granting a licence.

- That police forces be obliged to report any charges laid against physicians to the College as soon as the charges are laid.

- That the College report physicians guilty of sexual violation to other provincial Colleges of Physicians and other related professional bodies in Canada and the United States.

Currently, the College licensing procedure involves self-reporting by applicants of criminal charges or convictions and civil suits "related to the practice of medicine." For greater protection, we believe the procedure should specifically cover sexual abuse and that the College should check previous licensing bodies for such information.

Third Party Presence During Examinations

Strong Demand for a Third Party to be Present

Throughout our public and private hearings and in correspondence from survivors and advocates, there was strong support for a return to having a third party present during physical examinations, particularly breast and internal examinations.

For many, this would be a return to a practice they remember from some years ago. It is seen to have several advantages:

- It is seen to be a viable way to prevent a great deal of sexual abuse, because a third party would provide a deterrent to abusing. Many survivors we heard from felt that their abuse would never have happened if a nurse or other third party had been present.

- A third party present is seen to provide a witness for corroborative evidence to some of the less physically invasive forms of sexual abuse, such as inadequate draping or demeaning language.

- A third party is seen by some physicians to provide protection from misunderstandings of procedures by patients or from vengeful charges of abuse.

"This condition may not be a 100% cure but it would have saved me."

Quote from a survivor recommending a third party be present for examinations.

The College has advised the presence of a third party during a pelvic examination in writing since 1985. However, it appears that most physicians do not observe this guideline.

Issues Around A Third Party Being Present

While we heard a great deal of support for the presence of a third party, we also heard a number of concerns raised about the practice.

First of all, many patients consider the presence of a third party during an examination or consultation to be intrusive, and prefer to have no one else present. Others feel that it creates an uncomfortable atmosphere, particularly if they want to be able to discuss matters of a highly personal or intimate nature with their physician.

Physicians have expressed concerns over the additional cost to them of a third party, given that most of them already operate in a situation where

staff are overburdened and they would need to hire someone expressly for this purpose.

Some physicians and some patients suggested that these issues could be overcome by having the patient bring his or her own third party - a friend or family member. However, this might not be possible in every case, and assumes advance knowledge on the part of the patient of the kinds of examination that the physician might need to do.

Of particular concern to the Task Force, however, is significant evidence and experience that having a third party present is not always effective in preventing sexual abuse. The third party in an office practice situation is usually a subordinate of the physician and employed by him (and hence dependent on him for a livelihood). Experience has shown it is a common human reaction for the subordinate not to intervene when abuse occurs, to overlook small instances of abuse, or to find ways to remove herself from the situation while the abuse is occurring, as a means of avoiding having to confront her employer. The Task Force heard several reports of sexual abuse from patients which had followed this pattern.

Secondly, third party "supervisors" are frequently not trained to recognize all forms of abuse or in techniques of intervention. Therefore, they may miss things or handle the situation inappropriately (Schoener et al, 1989) Problems in the Use of Direct Observation in Probation Plans). Further, third party "supervisors" usually build sufficient trust in the physician over time that they become less vigilant, and can again miss evidence of abuse. (William Marshall, Ph.D., Kingston Sexual Behaviour Clinic, written communication to the Task Force, 1991.)

Conclusions

We are not convinced that having a third party present during physical examinations or other physician-patient interactions is a fully effective deterrent to sexual abuse of patients. Further, we believe that insistence on the practice may interfere, in some cases, with existing healthy physician-patient relationships and, in some cases, with the one-to-one contact needed to provide good care (for example, in psychotherapy). Many doctors have informed us that they are not able to bear the financial burden of providing this option

However, the practice may be important to some patients in creating a feeling of safety for them, particularly patients who have already experienced sexual abuse by someone they've trusted.

Therefore, we are recommending that the College re-issue the guideline that a third party be present for internal examinations, (Recommendation 14). We are recommending that the onus be on the physician to provide the third party, since patients cannot be expected to anticipate the types of physical examinations that may be required when they visit the physician. We are also recommending that this guideline apply regardless of physician/patient gender.

Providing Assistance to Survivors of Sexual Abuse

Physicians can play a very important role in helping patients who have been sexually abused. Survivors may be more willing to discuss the abuse with their physician than with others because of the special degree of trust in him or her. We have found, however, that survivors have often not been given appropriate assistance by physicians, and that better physician education is the key to addressing this (see "Education for Physicians", Chapter 3).

Given the prevalence of sexual abuse (see "Education for Physicians," Chapter 3), it is likely that every physician will be required to treat survivors of sexual abuse in his or her practice.

It is also likely that many physicians will be required to treat survivors of sexual abuse by a physician or other person in a position of trust.

There are four key aspects to the provision of appropriate assistance by physicians to survivors: recognition of the abuse, responding to reports, treatment, and support and referral.

Recognition of the Abuse

In some cases, a survivor will disclose sexual abuse directly and ask for help in dealing with the trauma.

In most cases, however, the sexual abuse will not be disclosed by the survivor, although it may be the cause of the symptoms with which he or she is presenting. Therefore, the physician needs to be vigilant to the possibility of sexual abuse, to inquire about it as part of history-taking, and to use a non-threatening style of questioning that recognizes the deep and complex feelings of pain, anger, shame, and self-blame the survivor may be feeling.

Patients who have experienced sexual abuse may present with a variety of psychological symptoms, such as anxiety, fear, depression, suicidal feelings, difficulty in relationships or loss of trust in the world or society. The psychological symptoms may resemble or complicate mental illness. If any of these symptoms are present, the physician must suspect sexual abuse, and enquire whether the patient has ever been sexually abused or experienced unwanted sexual activity. It is also important to determine whether these acts were perpetrated by a person in a position of trust, such as a parent or a physician.

Patients may also present with a variety of physical symptoms, including abdominal pain, pelvic pain, gastrointestinal tract problems, headaches, eating disorders, or drug and alcohol abuse. Again, the physician should consider past sexual abuse as a possible factor, enquiring about it as above.

Physicians must also be aware that it is characteristic of survivors to deny that abuse has occurred until they have built sufficient trust in the

caregiver to disclose, and even then may only partially disclose. This may be due to the shame and self-blame that is usually experienced by victims.

It may also be due to memory-blocking, a common defence mechanism used by the psyche to deal with trauma. The patient may be totally unaware of the abuse and its impact.

Responding to Reports of Abuse

To provide effective assistance to survivors, physicians must react to positive disclosures of abuse in a calm, supportive, and non-judgemental way. Survivors need to be believed and to have their experiences validated.

It is important, therefore, that the disclosure is accepted as the truth and that the survivor feels believed. Frequently, the first few times a caregiver hears a disclosure, his or her own reaction may be one of disbelief, especially if the perpetrator is someone in a position of trust, like a physician, or the survivor does not fit the caregiver's "image" of a survivor of sexual abuse. However, false disclosures of sexual abuse are rare, and the physician must operate based on the principle "suppose everything she says is true - what would I do then?" It is common for survivors to feel responsible for the abuse. Survivors need to have these feelings taken seriously and to be assured that they were not to blame.

The survivor also needs to be told:

- That it is important that he or she gets support and treatment to recover from the impact of the abuse, the kinds of treatment that are available (such as individual or group therapy, assistance through sexual assault care centres, and self-help groups for survivors), and that the physician is willing to help find this support.

- In the case of abuse by a physician (or by a caregiver in other self-governing professions) that there is a complaints procedure, what it involves, and, once Recommendation 15 is implemented, the obligation of the treating physician to report another physician to the College if the survivor reveals the physician's name or the treating physician knows the other physician's name.

- The other legal options available to the survivor - criminal or civil action against the perpetrator. This information should be in the brochure and the Law Society should include names of lawyers who have completed the training in Recommendation 6 as part of the Law Society referral service.

Treatment

The principles of treatment of sexual abuse involve allowing the patient to choose his or her therapist and the sex of the therapist. The therapy must be empowering and under the control of the survivor. The experiences and emotions of the survivor must be validated and seen as normal. Any reaction to abuse is part of a range of reactions that normal people have to

abnormal traumatic events. The therapist must be willing to continue with the therapy for a fairly long time. The survivor must never be blamed for the abuse, as most already feel unrealistically responsible as a reaction to their need to make sense of the abuse. Neither the therapist nor the patient must be allowed to cross sexual boundaries in the therapy, despite the fact that these boundaries may be tested.

Individuals who have had prolonged severe abuse beginning from a very young age have very often developed a post-traumatic stress disorder. This is a psychological disturbance resulting from experiencing one or more stressors greater than usually occurs in normal human experience involving fear, terror, pain, and helplessness. This can cause profound disturbances in the normally integrative functions of identity, memory or consciousness. It can also cause intrusive re-experiencing of any or all aspects of the stressful experience with distortions of time, person and place, and involvement of any or all of the senses. It often results in avoidance of stimuli which may trigger the intrusive memory. Psychic numbing and increased arousal are frequent accompaniments. These symptoms must last for more than one month. The principles of treating a post-traumatic stress disorder involve reliving the experience in a safe environment and relationship, abreacting emotionally to the memories, the adding of components providing security and meaning to the traumatic experiences, and the working through of the meaning of the events in the individual's life and how these have affected the individual. Dissociative disorders require specialization and a great deal of expertise in their treatment and this treatment should not be undertaken without extensive training and supervision.

The patient must be empowered to make all choices, including participation in therapy, getting legal advice, and suing or charging the perpetrator. The patient must not be pressured to do any of these things before he or she is ready.

It is important to recognize that effective care for abuse survivors requires specialized treatment and a long-term commitment - resources that many physicians do not provide. A physician without these resources should refer the patient to a qualified professional or community resource to ensure appropriate care.

Support and Referral

The physician should know local referral sources and have a list of addresses and phone numbers available. These resources need to include:

- Therapists (both physicians and other professionals) who are qualified to treat survivors of sexual abuse
- Support groups for survivors
- Sexual assault care centres
- Victim assistance programs
- Alcoholics Anonymous, Al-Anon, and other self-help groups that provide assistance with substance abuse
- Family service agencies

- The College of Physicians and Surgeons, and other Colleges
- Police
- Legal Aid or the Law Society of Upper Canada (LSUC) Lawyers Referral Service

When the physician refers the survivor to another health care professional, it is important for the physician to continue to be supportive and available if needed.

If the perpetrator of the abuse is a physician, and the survivor decides to make a complaint to the College, the physician may want to provide assistance to the survivor in drafting the complaint. If not, he or she should attempt to ensure that the survivor is able to get such assistance, if desired, from another source.

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CHAPTER 5

CHANGES INSIDE THE COLLEGE

In this chapter, we cover the specific thinking behind the following recommendations:

Recommendation 16

That the College make it a policy that any person who has knowledge of any sexual impropriety or sexual violation in a physician-patient relationship may report to the College, and the College must record and retain the information in relation to the physician, on a confidential basis, until the Registrar, in accordance with the statutory safeguards, including the approval of the Executive Committee of the College, proceeds with the investigation.

Recommendation 17

That reports by third-parties are to include the physician's name, but not the patient's name, unless the patient specifically so agrees in writing, and not the reporter's name, unless the reporter is a member of the College or unless the reporter agrees to identification.

Recommendation 18

That where there is more than one third-party complaint about a physician, the College's Director of Public Complaints and Investigations be required to bring the physician's file to the attention of the Registrar and the Executive Committee of the College, for a review of the evidence available and a decision on whether an investigation will be initiated.

Recommendation 19

That any person, health care facility, business, or organization be immune from civil liability for submitting a report of sexual impropriety or sexual violation to the College, when submitted in good faith and on reasonable grounds.

Recommendation 20

That the College immediately amend its licence application, guided by the precedent of the Law Society of Upper Canada (reproduced in Chapter 5), to include a non-exemptible requirement to answer questions to enable the Registrar and/or the Registration Committee to determine whether or not the applicant is of **good character** sufficient to be allowed to practise medicine in Ontario.

"I never could have believed that a man I only saw 40 minutes a week could rob me of so much. I long for a swift conclusion. I long to be treated with the dignity that was taken from me without my consent. I long to go on with my life with the knowledge that I did what was morally right, and that I saved others from the pain I've had to endure."

Quote from a survivor whose complaint is currently being investigated by the College

Recommendation 21

That physicians, as a condition of licensure or re-licensure, continue to be obliged to report on an ongoing basis to the College criminal charges against them and disciplinary action against them by other Colleges or professional bodies and be obliged to report civil suits initiated against them where the charges allege sexual abuse, and that the College check previous licensing bodies for such charges prior to granting a licence.

Recommendation 22

That the **Solicitor General of Ontario** be asked to initiate mandatory reporting to the Colleges listed in Schedule 1 of the **Regulated Health Professions Act** of any charge laid against an Ontario physician or other member of a Schedule 1 profession as soon as the charge is laid.

Recommendation 23

That where the College has made a finding of guilt of sexual impropriety or sexual violation, it immediately inform other provincial Colleges of Physicians and other related bodies in Canada and the United States, specifically the **Board Action Data Bank** kept by the Federation of State Medical Licensing Boards in Fort Worth, Texas, and that a protocol for mutual reporting be developed by the College with the **Federation of Medical Licensing Authorities of Canada.**

Recommendation 25

That the privacy of patient/complainants be better protected by the College, given the exceptions to secrecy proposed in the **Regulated Health Professions Act**, by:

1) Immediately beginning to delete the name of patient/complainants from documents accessible to College staff or lawyers and their staff; and,

2) Omitting graphic intimate details which may identify the patient including personal information unrelated to the facts of the physician abuse in the Report of the Discipline Committee which is public and widely distributed.

Recommendation 27

a) That the College, together with the Metro Action Committee on Violence Against Women and Children (METRAC) develop hiring criteria and performance standards for staff who will be involved with individuals contacting the College about sexual abuse.

b) That immediate, substantive and ongoing training be provided to all College staff who may, in any way, have contact with an individual inquiring or complaining about sexual abuse, (including receptionist, secretary, investigator, inspector, patient representative, and manager) as well as every member of Council, especially those sitting on,

or likely to sit on, the Complaints or Discipline Committee within the next two years. That this training must address the common tendency to blame the victim and must include at minimum:

- The nature of sexual abuse by physicians, the magnitude of the problem, the consequences to victims, and issues of race, gender, and class related to abuse.

- The range of ways a survivor may initiate disclosure or inquiry, and how to facilitate and handle disclosure, inquiries, complaints, and information dissemination in an appropriate, empathetic, and supportive manner.

- How to fully and appropriately explain the complaints and discipline process of the College to potential complainants.

- The options a complainant has to lodge a complaint of sexual abuse through the criminal and civil justice systems.

- How to address survivors and those making inquiries with sensitivity and respect (for example, not addressing or referring to an adult woman as "girl").

- The characteristics of Sexual Impropriety and Sexual Violation, as outlined in Recommendation 24.

"When I first started hearing about sexual abuse, my first reaction was disbelief. I didn't want to accept what I was being told. Then I began feeling angry when it dawned that sexual abuse is committed by people in positions of power and authority, against people who are powerless and dependent. Some of us with power forget what it is like to be without it. It took me a long time to come to grips with the extreme devastation that sexual abuse leaves in people's lives. For many victims, it is a life sentence. Crippled with shame, guilt and self-hate - some neve recover."

Dr. Carole Clapperton, President, Ontario College of Family Physicians

Changes in the Investigation and Complaints Process

Recommendation 28

That the College make it a policy that the entire complaints and discipline procedure, up to and including the final decision and options to appeal, be explained in full to a complainant before he or she is asked to make a written complaint, including the steps in the process, the disposition of medical records, the options available, the requirements of the complainant, the possible outcomes, and the resources the College will make available to him or her.

Recommendation 29

That there be very **frequent, clearly-worded communications** on the progress of the investigation, complaint, and discipline process between the College and the complainant and between the College and the physician and that care be taken that any communication from the College to complainants and physicians or their representatives be respectful and not attempt to intimidate or obstruct access to justice. That the College check with the complainant or physician to ensure that such communication has been understood.

Recommendation 30

That the College make it a policy to offer to complainants assistance in writing a complaint, including the assistance of a sensitive, trained investigator or patient representative, as well as provide whatever assistance is necessary to those complainants with **special communications needs**, such as language interpretation, cultural interpretation, or sign language interpretation and the ability to make the complaint on tape, if needed. That these resources be made available at College expense.

Recommendation 31

That the **College** make it a policy to offer to complainants support and/or counselling from outside the College throughout the complaints and discipline process if he or she does not have any, and so wishes, including **support, counselling, advocacy**, and whatever assistance is necessary for complainants with special communications needs, and continue to cover the costs of transportation, accommodation, and child care expenses. That these resources be made available at College expense.



Dr. Rachel Edney, Vice-President of the College and member of the Task Force, addresses a concern at a public hearing

Recommendation 32

That the **College** retain expert advice to develop an action plan on how to effectively encourage **women doctors** to serve on the Council and that the College encourage the **Minister of Health** to facilitate further appointments of women, including **women who are members of racial minorities or who are disabled, as public members**.

- That the College immediately increase the number of women and public members who sit on the Complaints and Discipline Committees; that the Complaints Committee and each panel of the Discipline Committee be composed of at least two women and the maximum possible number of public members; and that these panels be chaired by a member, not necessarily a doctor, with skill and training in adjudication of administrative tribunals.

- All members of the Complaints and Discipline panels are to be selected for their **demonstrated understanding and expertise** in sexual abuse as one principal criterion, in addition to being open-minded and knowledgeable in other areas deemed by the College as relevant to its obligations in regulating the profession.

- Before sitting on any of these panels, all members must have completed the **training program** being jointly developed with the Law Society of Upper Canada and METRAC (Recommendation 6) as well as the College's own internal training program, once these programs are available.

Recommendation 33

That the College continue its policy that when the Complaints Committee is satisfied that there is enough evidence of sexual abuse "on the face of the file" (prima facie), then the complaint should always be referred to the Discipline Committee.

Recommendation 34

That in sexual abuse complaints, the College begin immediately, as standard procedure, to exercise its existing **statutory authority to seize** the patient's medical records and any other relevant materials with a search warrant if required, at the beginning of the investigation process, without prior notice to the physician.

Recommendation 35

That the College use the revised confidentiality sections of the **Regulated Health Professions Act** to commence a specific investigation to determine whether other patients of the physician might be able to provide evidence related to the complaint by carefully reviewing the doctors' medical records for indications that other patients may be victims while ensuring that confidentiality of their medical records is protected. Each patient so contacted to receive a copy of the decision of the Discipline Committee within six weeks of that decision.

Changes in the Discipline Process

Recommendation 36

That the College continue its policy that any decision not to refer a sexual abuse complaint to the Discipline Committee must be supported with a **full explanation in plain language** given to the complainant, and make it a policy that there be a genuine opportunity for the complainant to ask questions and receive answers about the decision. At the same time, the complainant must be fully informed of the appeal procedure to the Health Disciplines Board and that this process is separate from the College.

Recommendation 37

That, in order to help reduce the delay in hearing sexual abuse cases, the College actively recruit the public members needed to increase the number of Discipline panels to two, until such time as the **Regulated Health Professions Act** allows for more panels.

Recommendation 38

a) That the College make it a **policy** that the patient/complainant has **guaranteed Intervenor status** in the hearing and the option to have a support person as well as her legal representative present throughout the hearing. Should the patient's **competence as a witness** become an issue at the hearing, the patient should have the right to participate as a **party.**

b) That the **Regulated Health Professions Code** be expanded to give the Complaints and Discipline Committees the same discretion to specify parties as is currently held by the Fitness to Practise Committee.

c) The **Regulated Health Professions Code** be amended to give explicit authority to the Discipline Committee to use its discretion in allowing public interest intervenors, who are not representing the individual or complainant but can bring important perspectives to the deliberations.

Recommendation 39

That the College make it a policy that, until the case is referred to the Discipline Committee, a complainant should be granted a reasonable **adjournment** - if she or he is feeling unable to continue.

Recommendation 40

That the College make it a policy that a prosecutor become involved in a case immediately upon a complaint being referred to Discipline, and that the complainant has a right to meet with the prosecutor, and participate in the **selection of this prosecutor** from a group of lawyers provided by the College.

Recommendation 41

That the College require that lawyers who prosecute sexual abuse cases for the College must have demonstrated expertise in the theory and practice of conducting a sexual abuse case and an appreciation of the impact on the complainant as well as on the physician. Once Recommendation 6 is implemented, that the College only allow lawyers who have completed the **program on sexual abuse** to act as prosecutors.

Recommendation 42

That the College make it a policy that the letter of complaint that goes to the doctor for response is not sent without the **complainant's explicit knowledge and consent.**

Recommendation 43

That the College immediately modify its current practice and require a pre-hearing procedure similar to that employed by the Ontario Pay Equity Tribunal and the Ontario Human Rights Commission, and to ensure the **fullest possible disclosure** of information from all parties prior to a hearing be required immediately.

Recommendation 44

That, when the defence puts forward good character evidence, the prosecution leads expert opinion that **evidence of good character** in professional and community life does not have any bearing on the **propensity** to sexually abuse.

Recommendation 45

That in all cases of sexual abuse, it should be argued by the College that the physician is incompetent due to his "disregard of the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice" as in the **Regulated Health Professions Code.**

Recommendation 46

That, to the greatest extent possible, all prosecutions for sexual abuse must present as part of the case before the Discipline Committee evidence related to **actual harm** to the abused patient, **risk of harm** to other patients, the high probability of repeat offending, and the current inability of rehabilitation programmes to determine **prospectively** that a particular abuser will not abuse again.

Recommendation 47

That the College hire an abuse survivor to assist the College in initiating the development of counselling resources for survivors of sexual abuse by physicians, including a **network of survivors** whom a potential complainant could consult with about the experience of pursuing a complaint before deciding to proceed.

Recommendation 48

That the College employ objective outside testing, on a regular basis, to ensure there is sufficient capacity to its **toll-free telephone line** to be accessible (i.e., not constantly busy) to a member of the public and that the College install a **TDD line** to meet the needs of hearing-impaired members of the public.

Self-Regulation of Physicians in Ontario

"Is self-regulation practical to implement in relation to the profession in question? In relation to this issue we considered the ability of the profession's leadership to favour the public interest over professional self-interest, the likelihood of compliance by members of the profession, and whether the number of members and their willingness to contribute are sufficient to bear the costs of self-regulation.

The important principle underlying each of the criteria is that the sole purpose of professional regulation is to advance and protect the public interest. The public is the intended beneficiary of regulation, not the members of the professions. Thus the purpose of granting self-regulation to a profession is not to enhance its status or to increase the earning power of its members by giving the profession a monopoly over the delivery of particular health services. Indeed, although these are common results of traditional regulatory models, they are undesirable results, and the model of regulation we recommend aims to minimize this."

Health Professions Legislation Review. Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions. (Ontario, Queen's Printer, 1989)

Health disciplines in Ontario are governed by the **Health Disciplines Act,** R.S.O., 1980 c. 196, as amended (the "HDA"). The HDA creates one Health Disciplines Board (the "Board"), and five "Colleges" - for dentistry, medicine, nursing, optometry and pharmacy, respectively.

These five professions are "self-regulating" in the sense that responsibility for licensing, registration and discipline of their members is entrusted to their "Colleges" which are composed primarily of members of the respective professions.

At the time of writing this Final Report, the successor legislation to the **Health Disciplines Act,** the **Regulated Health Professions Act, (RHPA)** was currently before the Standing Committee on Social Development of the Government of Ontario for clause-by-clause debate regarding the many amendments which have been proposed to the Act by all three parties. After the Standing Committee has referred its report to the Legislature, amendments to the proposed Act will be voted upon. It is anticipated that the Act and its Procedural Code will become law some months after the Final Report of this Task Force is released. In contrast to the five "Colleges" in the **Health Disciplines Act**, there are over 20 health professions to be regulated under the proposed RHPA and the **Health Professions Procedural Code**. The Health Disciplines Board is continued under the new Act as the Health Professions Board and serves as a body to hear appeals and review decisions made by committees of the Colleges. The new Act establishes an Advisory Council to advise the Minister on matters relating to the regulation of health professions. Most of the sections discussed in this chapter as part of the HDA will be continued in identical or equivalent form in the new Act. For this reason, this Task Force commentary will still be relevant when the new Act is proclaimed.

The College of Physicians and Surgeons of Ontario

Physicians are regulated by the College of Physicians and Surgeons of Ontario (the "CPSO"), which is the body appointed by the HDA to regulate medicine. The HDA provides for the following entities within the CPSO:

(a) the Council, which governs and manages the CPSO's affairs - HDA s. 48(1);

(b) five committees established by the Council, namely:
  (i) the Executive Committee;
  (ii) the Registration Committee;
  (iii) the Complaints Committee;
  (iv) the Discipline Committee; and
  (v) the Fitness to Practise Committee - HDA s. 53(1).

(c) a Registrar appointed by the Council, who performs various functions - HDA s. 48(7); 56; 58a(2),(3); 62(2); 63; 64.

The Council is specifically empowered:

(a) To pass regulations concerning various matters including standards of practice, discipline, and defining professional misconduct, subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister of Health - HDA s. 50; and,

(b) To pass by-laws "relating to the administrative and domestic affairs of the College", on its own initiative without ministerial approval - HDA s. 51.

"Supervision" of the CPSO is by the Minister, who may "review" the Council's activities, "request" it to act in a certain way, "require" it to provide information and "advise" it on various matters including the implementation of policies, regulations and procedures - HDA s. 49. This ministerial supervision is within the broader context of the Minister's duty "to ensure that the activities of health disciplines are effectively regulated...in the public interest. (s.3(1)).

The Health Disciplines Board

The Board functions essentially as an appellate body within the HDA. Its most significant roles in the context of the Task Force are:

(a) To hear appeals from a decision by the Complaints Committee not to refer a matter to the Discipline Committee - s. 8(2).

(b) To hear appeals from a decision by the Registration Committee refusing to register a doctor from another jurisdiction who either lost his licence or was under investigation for sexual misconduct - s. 11.

(c) To hear appeals from a decision by the Discipline Committee concerning reinstatement of a member whose licence has been revoked - s. 63(3).

CPSO Complaints System

As presently set out in the HDA there are two ways to initiate a process that can lead to a discipline hearing:

(1) By written complaint from a patient or another individual; or
(2) Action initiated by the Registrar.

(1) Written Complaint

Under section 58(1) the Complaints Committee shall "consider and investigate" all complaints, but can take no "action" without the following prerequisites:

(a) a written complaint;
(b) notice to the member whose conduct is being investigated;
(c) at least two weeks given to the member to respond; and
(d) the Complaints Committee "has examined or has made every reasonable effort to examine all records and other documents relating to the complaint".

Typically, the Committee's investigation is triggered by a written complaint. Unlike the investigatory powers of the Registrar, which are extensive and laid out in Section 64, the scope of the Committee's investigatory powers is not made clear in the Act. In practice, an investigator will interview the complainant and possible witnesses referred to by the complainant, and examine documents in the complainant's possession.

Once the four preconditions are met, the Committee generally has two choices before it:

(a) it may refer the matter to the Discipline Committee for a hearing; or,
(b) it may decide not to refer, in which case the complainant has a right to appeal that decision to the Health Disciplines Board.

(2) Registrar

The College has the power to initiate a review without a formal written complaint. Information may reach the Registrar by means unspecified in the Act, which enables the Registrar to form the opinion that a member may be guilty of professional misconduct or incompetence. In this event, under Section 64 of the Act, the Registrar "may" investigate with the approval of the Executive Committee, and thereafter report the matter either to the Council or the Executive Committee or "to other such committee as he considers appropriate", for example, the Complaints Committee. Any of these bodies may in turn refer the matter to the Discipline Committee.

Discipline Committee

The three functions of the Discipline Committee are:

(a) to hear evidence;
(b) to make a finding of fact and law regarding the guilt or innocence of the member; and
(c) to determine the penalty to be imposed on a doctor found guilty.

The **Statutory Powers Procedure Act (SPPA)** applies to proceedings of the Discipline Committee since hearings are specifically referred to in the HDA. The SPPA articulates the minimum standards for a hearing and where the HDA is more rigorous, the HDA prevails. That is why several of the Task Force's final recommendations propose amendments to the HDA or its successor which clearly override the provisions in the SPPA.

Any "party" to a Discipline Committee proceeding has a full right of appeal on questions of fact or law from a Committee decision to the Divisional Court - HDA s. 13 (The Divisional Court can substitute its opinion for

that of the Discipline Committee -s. 13(2) or send the matter back to the Committee for re-hearing). With respect to a decision whether to reinstate the member, however, the appeal is to the Health Disciplines Board, whose decision is final - HDA s. 63(3).

Perspective

"Graphic details are often published in the College's Report on discipline hearings which the newspapers and public have access to. For the abused individual this is a permanent record of her shame and intimate details about her life.

Does the public really need to know any more intimate details? Clearly if the report were only to go on and simply state what the sexual impropriety was, that would be enough. Any further details somehow permit the focus to shift to the victim again and becomes another source of her revictimization."

June 18, 1991 correspondence to the Task Force from Marlys Edwardh, B.A., LL.B., LL.M., for a patient who had experienced the College disciplinary process

A major part of our work has been to review the effectiveness of the College's policies, practices, and procedures for dealing with sexual abuse of patients. In addition to meeting with College staff, members of the Complaints and Discipline committees, and College prosecutors, we listened to complainants and legal counsel who have experienced the College process or who are presently in the midst of the process. We also reviewed approximately 25 closed complaints and discipline files. We were not allowed to review files of complaints in progress.

The College, as a self-regulatory body, has a mandate to protect the public. This implies an obligation to identify and remove sexual abusers from the profession. With this as the goal, the implications for the College are that it must:

- Get complaints about physicians who are sexually abusing into the system, so they can be investigated.
- Once in the system, get the fullest possible information to the adjudicators of the complaint, so that they can make the most accurate determination of guilt or innocence of the physician.
- Ensure the adjudicators have the appropriate expertise to make that determination.

We believe that it is also important that the complaints and discipline process at the College be as humane as possible. This will encourage reporting. It is also important for the profession, since it can help to restore the faith of the survivor that while there are some physicians who abuse, the majority are good, ethical, and caring.

It is from this perspective, then, that we examined the existing complaints and discipline process at the College.

Legal Jurisdiction of the College

The complaints and discipline process of the College is primarily defined by the **Health Disciplines Act**. This Act, and the Regulations under it, create five Colleges, and currently govern five health disciplines: medicine, dentistry, nursing, optometry, and pharmacy. These professions are self-regulating, meaning that the responsibility for licensing, registration, and discipline of their members is entrusted to bodies composed primarily of members of the respective professions.

The **Health Disciplines Act** identifies the composition of the Complaints and Discipline Committees, what their duties are, and what type of penalties the committees can impose. It requires that the Complaints Committee cannot act before it has a written complaint, has provided notice to the member of the complaint, has given him or her at least two weeks to respond, and has examined all documents and other records relating to the complaint. Once these things are completed, the Complaints Committee can refer the complaint to the Discipline Committee or can refuse to refer it, in which case the complainant can appeal the decision to the Health Disciplines Board.

The Act defines "incompetence" and the Regulations passed under the Act define "professional misconduct." The Act requires that the Discipline Committee hear evidence, make a finding of fact and law regarding guilt of incompetence or professional misconduct, and impose penalty, at its discretion, upon a finding of guilt.

"The way in which the profession responds to challenges posed by offenders can affect not only the safety of future patients (i.e. potential victims) and the integrity of the profession, but also the recovery process of those who have already been abused."

Sonne and Pope, 1991

The Act delineates the circumstances under which licence suspensions or revocations take effect immediately, and when they do not take effect until the appeal process is finished.

The Act also allows the Executive Committee and the Registrar of the College (under Section 64 of the Act) to initiate an investigation of a member when believing on reasonable or probable grounds that the member has committed an act of professional misconduct or incompetence.

The Complaints and Discipline Process: Key Steps

The broad steps in the complaints and discipline process at the College are as follows:

- Upon receipt of a written complaint, or at the initiation of the Registrar under Section 64 of the Act, an investigation is initiated by the College.

- Once the investigation is completed, the information goes to the Complaints Committee, which determines if the complaint will be referred to the Discipline Committee.

- If referred to Discipline, a Discipline panel composed of members of the Discipline Committee holds a hearing, makes a finding of guilt or innocence, and imposes penalty. Any party to the Discipline Committee proceeding (currently, the College or the physician, but not the complainant) can appeal the Discipline Committee's decision to Divisional Court, except if the appeal is about whether to reinstate the physician, in which case the appeal is to the Health Disciplines Board. The Divisional Court can affirm or rescind the decision of the Discipline Committee. It can substitute its opinions for that of the Discipline Committee or refer the matter back for re-hearing.

There have been some changes in the detailed steps of the internal College process over the last year. Therefore, we will outline the process up to that time, the recent changes, and our other key findings, and then discuss our recommendations.

What the Process Used to Be

The preliminary step in the process was usually a phone call to the College to report the abuse or to inquire about the process. For a discussion of our findings and recommendations on the phone process, see "Education for the College" in Chapter 3.

Upon receipt of a written letter of complaint, an investigator/inspector was assigned to the case. The investigator/inspector obtained medical records and other documents considered relevant to the case. Although the Registrar has the power under the **Health Disciplines Act** to seize medical records from the physician, this was seldom done. Many people believe that there will be nothing in the medical records that will point to abuse. However, we have learned that there are often indicators of abuse in the files, such as "mementos" placed there by the physician which can be used to re-experience the excitement of the sexual abuse when the patient is not there. We also learned that, if the physician had warning that the files were to be seized, he sometimes destroyed parts of the records or altered them, either to remove evidence or to make additions that would act to discredit the complainant.

Quote from patient who withdrew from complaint:

"I was prepared to do this for them without any support for me, so I had to be on my own. I was used by them and left to pick up the pieces all by myself. If they had pursued me and treated me differently, I could be persuaded to participate."

The investigator seldom interviewed the complainant. Out of the 108 sexual abuse complaints received by the College between 1987 and 1990, only 37 complainants were interviewed (Source: College Statistics). This meant that the comprehensiveness of the patient's written complaint, usually prepared without legal or other assistance, was vital to the case as it would be the crux of the complaint when reviewed by the Complaints Committee.

As required by the **Health Disciplines Act,** the patient's written complaint was sent to the physician for response. The physician may simply deny the complaint or may provide an explanation. Physicians often use a lawyer to prepare this response. Through membership in the Canadian Medical Protective Association, physicians have easy access to prepaid legal representation in disciplinary cases. The Act requires that the physician be given at least two weeks to respond. Some complainants waited for months for the physician to respond; some physicians actually moved to avoid contact with the College, delaying the process significantly.

Throughout the process, there was often little or no information on the progress of the complaint provided by the College to either complainant or physician. Complainants were often fearful of reprisals by the doctor, which made the lack of progress reports particularly traumatizing for them. In addition, some complainants told us that the correspondence they did receive from the College (particularly when they were pressing for information on the status of their case or requesting greater urgency) was blaming, trivializing, or intimidating.

Based on the information collected by the investigator, including the written complaint and the physician's response, the Complaints Committee considered whether to refer the complaint to the Discipline Committee for a hearing. If the Committee decided not to refer to Discipline, a short letter went out to the complainant and the physician. Both complainants and physicians reported that they found the explanation of the reasons behind the decisions to be inadequate.

Women lawyer/survivor at private hearing with Task Force in March 1991:

"Wake up. Get real. You guys have got a problem and you better fix it. I am able to access the system, yet I have difficulty; there are 100 people out there who can't do what I can do."

If the Complaints Committee decided to refer to Discipline, the next step was the discipline hearing. At the hearing, the physician had legal counsel provided by the Canadian Medical Protective Association. The physician was a party to the proceedings. The complainant was a witness to the proceedings, not a party. The College's case, based on the complainant's information, was put forward by a prosecutor appointed by the College. Under the **Statutory Powers Procedure Act**, the complainant has a right to bring her own legal counsel to represent her (at her own expense). However, most of the time complainants had not been informed of this right, and therefore had not brought their own counsel.

The hearing may be open or closed at the discretion of the Discipline Committee, not the complainant. In practice, no witnesses in a sexual abuse case have had to give evidence in public if they requested that their part of the hearing be closed. However, the possibility that the hearing could be open has deterred some from laying complaints. The physician, as a party, has the right to be present throughout the entire hearing. The complainant, as a witness, does not, unless the Discipline Committee allows it. This has meant that the complainant had often been excluded from hearing the testimony made by the physician about her, and had no opportunity to discuss the testimony with the prosecutor if she wished to refute it.

Complainant testimony re: experience with a College prosecutor:

"I was very uncomfortable telling this man and making excuses, roundabout descriptions. He kept interrupting me and saying, 'Get on with it,' and 'Why are you making excuses?' He just couldn't understand how difficult it was for me to tell the details, especially when he was so critical."

The complainant's sexual history, personal history, and psychiatric history (including intimate details of what she and the physician discussed in therapy) have often been used by the defence in attempts to blame the patient for the abuse and to discredit her. Delays in reporting the abuse have also been used by the defence to discredit the complainant, and the Discipline Committee had not recognized such delays as a common reaction of survivors of sexual abuse.

Before the hearing starts, the College prosecutor must make full disclosure of the College's case; the defence is not required to disclose anything. This is similar to criminal proceedings, but the College process is a civil proceeding and the Discipline Committee could require disclosure from both parties.

The patient's identity is not protected in College hearings except from the general public and the media. Her name, her medical files and the details of the abuse are available to staff at the College and to staff at the law firms involved, including secretarial staff and students. Although all those having access to such files are bound by confidentiality requirements laid out in the **Health Disciplines Act** (Sec. 65(1)), the Task Force recommends the procedure of the Massachusetts Board of Registration in Medicine where complainant's names are removed from documents sent out. Further, details of the patient's abuse and personal life, which can be identifying if the

patient lives in a smaller community or has disclosed some aspects of the abuse to others, are published in the College Report of the Discipline Proceedings, which is available to the public and the media. In at least two cases we reviewed, this kind of detail resulted in complainants being identified in the media or to colleagues, an excruciating experience for them.

Recent Changes

The College has recently made a number of changes to the complaints and discipline process:

- The addition of two Patient Representatives, available to answer questions from patients on the complaints process or the College.
- The use of female Investigators for sexual abuse complaints, who are going to receive special training in sexual abuse.
- The ability by the Complaints Committee to ask questions of College investigative staff at the time the complaint is presented to the Complaints Committee.
- The establishment of a policy of interviewing complainants, at a location of their choosing, and assistance by the College Investigator in drafting the written complaint following this interview.
- Some attempts at "fast tracking" of sexual abuse complaints through the system, by giving priority to these complaints through to Complaints Committee; however, they are delayed at discipline because more discipline panels are needed to reduce the backlog.
- More frequent contact with complainant and physician on the status of the case.
- The practice by the Complaints Committee of referring almost every sexual abuse complaint to discipline. From 1987 to 1990, only 26 of the 99 sexual abuse complaints referred to the Complaints Committee were referred to Discipline (Source: College Discipline Statistics); now, any case with enough evidence "on the face of the file" is so referred.
- The creation of a specialized pool of lawyers for the College to prosecute sexual abuse cases. While these lawyers now handle more cases of sexual abuse, they have as yet received no training on sexual abuse and the College has continued to retain the same lawyers as before the Task Force findings.



Some survivors addressed the Task Force through a support person

- The inclusion of a female member on the Discipline panel assigned to sexual abuse cases. However, demonstrated expertise in sexual abuse is not yet a factor in this assignment. This is of concern because we have found that many women have the same troubling misperceptions about sexual abuse as men.

- The practice, when the Complaints Committee does not refer the case to the Discipline Committee, of writing much fuller reasons for dismissal.

In all other ways, the process continues to be the same as it has been in the past.

Key Findings about Complainants' Experience of the Process

Many complainants we listened to, including those going through this process after the recent procedural changes, described the College process as daunting, traumatizing, and abusive. Some described the College procedure as more abusive than the original sexual abuse, due to a variety of behaviours on the part of the College:

- The College disbelieved the report of the patient, trivialized its impact on her, or suggested that she was somehow responsible. These reactions were experienced at the time of first contact with the College, in interviews or communication with College staff or prosecutors, in the hearing or in the correspondence. These College responses are typical of those not trained in the nature of sexual abuse and how to deal with it in ways that assist the survivor.

- The complainant found she had limited input into the process, although it was based on an incident of extreme importance to her. For example, she had no say in the selection of the prosecutor, was not always allowed to attend the hearing, and could not necessarily hear the doctor's testimony. The timing of the process was completely out of her control. These kinds of experiences left complainants feeling powerless over the process and unimportant.

- The intimate details of the abuse, her sexual and psychiatric history, and her vulnerability were exposed and often used to discredit her. For some survivors, the prospect of this alone prevents them from making a complaint to the College. For others who chose to proceed, even preparing themselves for the likelihood that this part of the process would be emotionally difficult for them did not prevent the trauma of experiencing it.

- Fears about reprisals by the doctor were often trivialized by College staff. Yet some patients experienced threats from the physician that he would kill them, kill their children, or take their children away if they proceeded with the complaint.

- Delays of weeks or months in obtaining and providing the response of the physician.

- Lack of communication from the College, including months without word on progress.

It is important to note that complainants who have contacted us since the recent changes in College policy are still expressing strong dissatisfaction about the process. While these complainants have generally been appreciative of the opportunity to work with a female investigator and have found them supportive, they continue to face the same problems with the process that have been in place for some time. The existing processes for the hearing continue to be experienced as biased in favour of the doctor and traumatizing for the complainant.

Conclusions

The recent changes made by the College in the complaints and discipline procedure are encouraging steps in the right direction. However, we also believe that much more significant change is needed to provide an effective process.

Many of the policies, practices, and procedures that have contributed to public perception that the process is biased in favour of doctors or have provided obstacles to complainants continue to exist. These act as a deterrent to complaints of abuse coming into the College system.

We have concluded that the information gathered through the investigations and the evidence provided for the hearings has not consistently been of the thoroughness and relevance necessary for the Discipline Committee to make the most accurate finding of guilt or innocence or to determine the most appropriate penalty.

There is still a substantial need to improve the expertise of both adjudicators and prosecutors for the College, another key factor in ensuring that the most appropriate decisions are reached (see "Education for the College" and "Education for Prosecutors," Chapter 3).

We are therefore recommending a number of changes to the registration, complaints and discipline process inside the College, (see Recommendations this chapter) and to existing statutes (see Chapter 6 Recommendations and the Legal Appendix).

Recommendation on the Registration Process

The Task Force was informed of criminal charges for sexual assault on patients brought against a graduate of an Ontario medical school who is licensed by the College and practising in Ontario. Throughout Ontario there have been a number of such criminal prosecutions, but we mention this particular case because the doctor had been convicted of sexual assault on a child prior to completing medical school; completed his undergraduate medical education and was licensed by the College. This case prompted the Task Force to review the application form used by the College's Registration Committee. The current registration form requires information about the applicant's name, birth date, address, citizenship, undergraduate educa-

tion, language proficiency, postgraduate education, medical licensing examination, internship and residency training and rating and allows the College to make inquiries it considers appropriate. The authorization signed by the applicant also states;

> I further authorize the College of Physicians and Surgeons of Ontario to revoke any licence issued to me if it subsequently appears that I have, by omission or commission, given false, misleading or ambiguous information in respect of any question on this application form.

The Task Force has concluded that the questions on the current application form are not sufficient to safeguard the public, because the Registration Committee is not asking questions which will enable it to determine whether an applicant, aside from being technically qualified, is also of good character sufficient to obtain the privilege of practising medicine in Ontario.

When a medical student fails to meet the academic standards, even by one percentage point, that student is not given a medical degree.

When an applicant for a medical licence has been rated as a failure on any of the qualifying exams, that applicant is not given a licence to practise medicine.

Recommendation 20 proposed that all applicants should have to answer, without exception, questions about previous or current criminal charges and/or convictions and current allegations of professional misconduct, incompetence or incapacity as well as any findings of such. The Task Force has reviewed changes to the application form proposed by the College and has concluded that they are insufficient in two respects:

1) They will not provide information to the Registration Committee about previous charges or allegations which were not adjudicated or where there was a finding of not guilty.

2) They do not allow the Registration Committee to consider, as an essential part of testing eligibility to practise medicine, whether or not the applicant is of good character.

The Task Force noted with concern that the College has often waited until criminal charges relevant to a doctor's competence to practise medicine were decided in court, before commencing to investigate or discipline the doctor. That has not been the practice of the Law Society of Upper Canada and indeed, the College recently changed its approach in the Mohan case, where it revoked the licence of a paediatrician who was in the midst of appealing his criminal conviction for sexually assaulting several of his teenage female patients. We believe the Registration Committee should gather information about sexual abuse allegations/charges which have not been adjudicated (for example, because the complainant suffered post-traumatic syndrome and withdrew) or where there was a finding of not guilty and ask questions about good character.

Why? Because the College has the responsibility to conduct its own investigation and to reach its own conclusions about eligibility to practise medicine, not delegate that responsibility to the courts.

The Task Force is recommending that the College's licence application form be amended to include questions similar to those asked by the Law Society of Upper Canada in Schedule 'A' of the Society's Bar Admission Course Application form, as follows:

GOOD CHARACTER

Section 27(2) of the *Law Society Act* requires that an applicant for admission to the Society shall be of good character. All applicants shall answer the following questions. Their purpose is to enable the Admissions Committee to determine whether or not the applicant is of good character. If the answer is "yes" to any of the following questions, give full particulars on a separate piece of paper to be attached to the application form.

An affirmative answer to any of the following questions does not necessarily mean that the applicant will be refused. In any event, before any application is refused, the *Law Society Act* gives the applicant an opportunity to appear in person before a committee of the benchers.

1. Have your ever been found guilty of any offence under a statute in jurisdiction in Canada or abroad.	**Yes**	**No**
2. Has judgment ever been entered against you in an action involving fraud?	**Yes**	**No**
3. Are there any outstanding civil judgments against you?	**Yes**	**No**
4. Have you ever disobeyed any Order of any court requiring you to do or abstain from doing any act?	**Yes**	**No**
5. Have you ever been discharged from any employment?	**Yes**	**No**
6. Have you ever been suspended, disqualified, censured or disciplined as a member of any professional organization?	**Yes**	**No**
7. Have you ever been denied or had any licence or permit revoked due to lack of good character?	**Yes**	**No**
8. Have you ever been refused registration as a student-at-law or articles clerk or similar position?	**Yes**	**No**
9. Have you ever been suspended or expelled from any educational institutions?	**Yes**	**No**
10. Is there any event, circumstance, condition or matter not disclosed in your replies to the preceding questions touching upon your conduct, character or reputation that might be an impediment to your admission, such as dependency on alcohol or drugs?	**Yes**	**No**

In a recent decision of the Committee of Benchers of the Society, it is stated:

> ...this Committee has felt bound to consider all the evidence...and is unconstricted by the rules of admissibility relating to criminal indictment.
>
> - In respect of the Application of M. J. Spicer
> Decision Released: October 3, 1991

In that case the Committee considered evidence as to the applicant's good character, including documents and testimony about the criminal charges of sexual assault of which he had been acquitted. The Committee defined good character for admission applicants as follows:

> "Character is that combination of qualities or features distinguishing one person from another. Good character connotes moral or ethical strength, distinguishable as an amalgam of virtuous attributes or traits which would include, among others, integrity, candour, empathy and honesty."

The Committee considered the evidence before it, exercised its responsibility to determine whether an applicant is fit "to be entrusted with the mantle of membership in the Law Society of Upper Canada", and the application for admission was denied.

The Task Force recommends that the College develop similar questions to be added to the Licence Application form and that the College develop a definition of good character consistent with its adopted philosophy of **Zero Tolerance** of sexual abuse of patients.

Recommendations on the Investigation and Complaints Process

Explanations to Complainants

We are recommending that the entire complaints and discipline procedure, including what is required of the complainant and all possible outcomes, be explained to every potential complainant before a formal complaint is made (Recommendation 28). This should be done by the investigator or patient representative trained in sexual abuse. As part of this process, the brochure on the College process (Recommendation 7) should be provided to the patient, in addition to any verbal explanation.

We believe this explanation to be important to ensure that patients are as prepared as possible for the rigours of the complaints and discipline process and can make an informed decision about whether they are ready to proceed.

Assistance to Complainants

We are recommending the implementation of a number of policies designed to provide support and assistance to complainants:

- Assistance in drafting the letter of complaint (Recommendation 30).
- Expanded support throughout the complaints and discipline process, including counselling and advocacy support (Recommendation 31).
- The ability to put a hold on the process if the complainant is feeling unable to continue, until the complaint is referred to Discipline (Recommendation 39).

Assistance in drafting the complaint, if desired by the complainant, will help to ensure that the complaint is thorough and comprehensive, important factors in the development of the fullest possible information for the Complaints Committee to review. This recognizes that for some complainants, writing about details of the abuse is traumatic, sometimes so traumatic that the complaint cannot be made at all. It also ensures that the complainant receives equivalent support to the doctor, who always has the option of receiving legal assistance in drafting his letter of response to the complaint, through membership in Canadian Medical Protective Association.

Expanded support throughout the process, if desired by the complainant, will help to make the process more humane for her and ensure that the support she needs to proceed is accessible to her. This will help to ensure that complaints stay in the system.

The ability to put a hold on the process recognizes the reality that despite support, the process may be extremely retraumatizing for the complainant. For the complainant who is unsure that she can withstand the rigours of the process, such a safeguard may be enough to get the complaint to be made, so the College can investigate it.

We are recommending that the toll-free telephone line to the College be tested regularly for accessibility and that a TDD line be installed. These measures will ensure that the College is indeed accessible to members of the public, including those with hearing impairment.

We are also recommending that the College develop hiring criteria and performance standards for staff dealing with sexual abuse. This will help the College to ensure that staff are able to perform their jobs in ways that support the achievement of **Zero Tolerance** and provide needed assistance to complainants.

Composition of the Complaints and Discipline Committees

We are recommending a number of changes to the composition of the Complaints Committee and each panel of the Discipline Committee:

- Changes in selection criteria for the members, such that demonstrated understanding and expertise in sexual abuse is one principal criterion, in addition to others required by the College.

- Mandatory training to increase understanding about sexual abuse for all members of the Complaints and Discipline Committees.

- Increases in the number of public members on the Complaints Committee and each panel of the Discipline Committee from one to two, a policy that wherever possible, at least two members on each panel be women, and that the College actively seek ways to recruit more women for Council to facilitate this.

- More definitive qualifications for the chairperson of the Complaints Committee and on each panel of the Discipline Committee, such that selection is based on skill and training in adjudication of administrative tribunals (Recommendation 32).

We believe that demonstrated expertise and training in sexual abuse are necessary to ensure that those making decisions about the quality of evidence and information and findings of fact, law, and penalty make the right ones. We believe it is important that the decision-makers at the College base their decisions on the realities of sexual abuse, not on misperceptions.

We are recommending more women on the panels to change the current perception that the panels are not fair and that they do not reflect the make-up of society, because they are made up almost entirely of men. We have concluded that the current perception of unfairness by survivors of physician sexual abuse is an obstacle to complaining about the abuse to the College in many cases. The combination of selection based on gender and demonstrated expertise in understanding sexual abuse should improve perceptions of fairness. This Task Force recommendation has been highly criticized for creating 'bias' if there are more women. The only expertise which physician members bring to the Discipline Committee is their expertise at being doctors. While this is important in competence hearings, its effectiveness in sexual abuse cases is debatable. At the present time, the College is choosing <u>not</u> to appoint to the Complaints or Discipline Committee, a woman public member who already has demonstrated expertise in the dynamics of sexual abuse, and who has offered to serve on these committees .

We believe that an increased number of public members on Complaints and Discipline Committees will also improve perceptions of fairness and facilitate increased reporting of abuse. The statute could be interpreted by the College to state a <u>minimum</u> of one public member, rather that being used to justify the least possible number of public members on these crucial committees

Finally, we believe that ensuring that the chairpersons of the panels have skill and training in adjudicating administrative tribunals is important given the complexity and sensitivity of sexual abuse cases.

Referrals to the Discipline Committee

We are recommending that the Complaints Committee continue its recent policy of referring sexual abuse cases to Discipline if there is enough evidence "on the face of the file" (Recommendation 33). Under the **Health Disciplines Act** it is the explicit role of the Discipline Committee, not the Complaints Committee, to make findings of law and of fact regarding the complaint.

We are also recommending that, if the Complaints Committee decides not to refer the case to Discipline, a full explanation be given to the complainant, along with a genuine opportunity to ask questions and a full explanation of the appeal procedure (Recommendation 36). This is important to ensure the complainant does not feel her complaint has been trivialized. This is also important to dispelling current public perceptions that the College is biased in favour of physicians and "looks after its own."

Investigation Procedures

We are recommending that the College make it a policy to seize medical records and other relevant materials from the physician at the beginning of an investigation initiated by the Registrar under Section 64 of the **Health Disciplines Act** (Recommendation 34). This recognizes the importance of the information that may be in the files and prevents the opportunity to alter or destroy important evidence. This recommendation is within the existing jurisdiction of the College under the **Health Disciplines Act** and requires no change in law to implement. Where an investigation has been triggered by a written complain, the Complaints Committee, under present law, does not have powers of seizure. However, the Registrar may after having used the Section 64 power, refer the report to the Complaints Committee.

We are also recommending that, once the Complaints Committee has referred the case to Discipline, the College consider carefully whether to commence a specific investigation to determine whether other patients of the physician might be able to produce evidence related to the complaint (Recommendation 35).

This recommendation recognizes that in many cases, if a physician has abused a patient, there is a likelihood that he has abused other patients (see "The Reality of Risk of Harm," Chapter 2). Such an investigation ensures that the fullest possible information about the physician and the likelihood of his abusing can be made available to the Discipline Committee in making its decision.

It is important to note that this additional investigation would not be initiated until the Complaints Committee was satisfied that there was already sufficient evidence of the abuse to merit a hearing by the Discipline Committee. Therefore, we believe that concerns expressed to us, following our Preliminary Report, that this investigation amounted to a "witch-hunt", are not founded. (See Legal Appendix). We are also recommending that should a doctor be found not guilty, patients previously contacted by the College be informed by the College of the outcome of the discipline hearing.

Progress Reports to the Complainant and the Physician

We are recommending that there be frequent, clear and respectful communication between the College and the complainant and the College and the physician throughout the entire complaints and discipline process (Recommendation 29).

While there have recently been improvements to the frequency of the communication by the College, the recent feedback we have been receiving from complainants indicates that complainants (and we suspect physicians) are still experiencing periods longer than a month with no communication from the College. This continues to be traumatizing. It is also important for the College to check that the communication has been understood to reflect a sensitivity to the problems an individual with visual impairment may experience in understanding written correspondence and to ensure that all participants understand the often highly legalistic nature of the process.

Recommendations on the Discipline Process

Recruitment for the Discipline Committee

We are recommending that the College actively recruit more public members, in order to provide a sufficient number of public members for the Discipline Committee to maintain two discipline panels and thus reduce delay in hearing sexual abuse cases (Recommendation 37).

Prosecutors

We are recommending that the College make it a policy to assign and involve a prosecutor in a sexual abuse case as soon as the case is referred to Discipline, and that the complainant be involved in the selection of the prosecutor (Recommendation 40). We are also recommending that the pool of prosecutors used by the College for sexual abuse cases be selected based on demonstrated expertise in sexual abuse and be required to complete the training course for prosecutors outlined in Recommendation 6.

We believe that early involvement of the prosecutor and the ability of the complainant to participate in selection are important in making the process more humane for the complainant, because they provide an opportunity to increase her involvement in the process. This change should also contribute to an increased perception by the public that the College is not biased in favour of the physician.

We believe demonstrated expertise and training in sexual abuse are required to ensure that the best possible evidence is placed before the Discipline panel. This should also reduce the risk of College decisions being overturned by Divisional Court based on weak evidence on the record. Finally, such training and expertise will ensure that the prosecutor is as sensitive as possible to the emotions and personal needs of both complainant and physician, resulting in a more humane process.

Patient as Intervenor: Immediate Change

We are recommending that the patient-complainant be given Intervenor status at the hearing by the Discipline Committee (Recommendation 38). This **immediate** change will bring more equity to the balance between the rights of the patient and the rights of the physician at the hearing. The patient deserves the opportunity to be present throughout the hearing, and for her legal representative to cross-examine witnesses, including the physician.

Only full party status gives the patient the same right as the doctor to appeal the decision of the Discipline panel to Divisional Court. We are recommending that the statute could be amended to follow the precedent for a College committee having the discretion to specify a patient/complainant as a party: Section 62(5) of the HDA gives this power to the Fitness to Practise Committee.

Such change should substantially improve public perceptions that the procedure at the College is a fair one, resulting in greater willingness to report abuse and more effective self-regulation.

Evidence

"I was very uncomfortable telling this man...He kept interrupting me and saying, 'Get on with it' and 'Why are you making excuses?' He just couldn't understand how difficult it was for me to tell the details, especially when he was so critical."

Complainant testimony re: Experience with a College Prosecutor

We are recommending that the College make it policy that particular kinds of evidence be led as part of the College's case against the physician:

- Expert opinion that evidence of good character in professional and community life does not have any bearing on the propensity to sexually abuse, to be led when evidence of good character is led by the defence (Recommendation 44).

- Evidence of the actual harm caused by the abuse to the patient, based on the patient's experience of it.

- Evidence of the **risk of harm** posed to other patients by a physician who is abusing.

- Evidence of the high probability of repeat offending and the current inability of rehabilitation programmes to determine prospectively that a particular abuser will not abuse again (Recommendation 46).

Our review of College discipline cases, interviews with complainants, and an interview with one doctor convicted by the College of "sexual impropriety" document that many physicians guilty of sexually abusing patients are able to bring forward evidence of good character in professional and community life at the same time as they are abusing. Our conclusion that such good character evidence has no bearing on the propensity to sexually abuse is supported by expert opinion among members of our Advisory Council who have demonstrated expertise in understanding sexual offenders. We believe that such expert opinion must be considered by the Discipline Committee when making its finding of guilt or innocence (See Legal Appendix).

We have also found that evidence as to the actual harm caused the patient by the sexual abuse has not consistently been led by the College prosecutor. This has led to trivialization of the seriousness of the abuse to the patient and, in our opinion, to lighter than appropriate penalties in some cases. As outlined in Chapter 2, past Discipline Committees have made their own subjective judgement of what the experience of abuse might have been like to the patient, instead of considering her evidence about it. This also trivializes the abuse.

We believe it is important to lead evidence of the **risk of harm** because the risk of harm is rarely identified by adjudicators of sexual abuse cases, and when it is identified, it is usually profoundly underestimated. Yet it is an important factor when considering penalty (see "The Reality of Risk of Harm," Chapter 2).

Finally, we have found that the effectiveness of rehabilitation today (see "Can Abusing Physicians Be Rehabilitated?" Chapter 2) is exaggerated, and has been a factor in light penalties by the College and in decisions to return an abuser to practice. Evidence on the high rate of repeat offending and the uncertainty that rehabilitation can be effective must, therefore, be led through qualified experts in order that the Discipline Committee can consider it.

Sexual Abuse as an Issue of Competence of the Physician

We are recommending that in all cases of sexual abuse, the College should argue that the physician is incompetent due to his "disregard of the welfare of the patient of a nature to an extent that demonstrates he is unfit to continue to practice," as in Section 60 (4) of the **Health Disciplines Act** (Recommendation 45).

We believe that a physician who is sexually abusing is incompetent because he demonstrates flagrant disregard for the damage caused to the patient and disregard for the patient's well-being. The finding that the physician is guilty of "incompetence" allows the penalty imposed by the Discipline Committee to take effect immediately, whether or not the physician decides to appeal the decision to Divisional Court. In comparison, if the physician is found guilty of "professional misconduct" - where "sexual impropriety" cases currently fall - the penalty does not take effect until after the appeal period is over. The finding of incompetence does not interfere with the doctor's right to appeal but recognizes that risk of harm to other patients exists if a doctor found guilty of abusing patients is allowed to continue to practice.

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CHAPTER 6

CHANGES OUTSIDE THE COLLEGE

In this chapter, we cover the following recommendations:

Recommendation 22

That the **Solicitor General of Ontario** be asked to initiate mandatory reporting to the Colleges listed in Schedule 1 of the **Regulated Health Professions Act** (RHPA) of any charge laid against an Ontario physician or other members of a schedule 1 profession, as soon as the charge is laid.

Recommendation 23

That where the College has made a finding of guilt of Sexual Impropriety or Sexual Violation, that it inform other provincial Colleges of Physicians and other related bodies in Canada and the United States, specifically the **Board Action Data Bank** kept by the Federation of State Medical Licensing Boards in Fort Worth, Texas, and that a protocol for mutual reporting be developed by the College with the **Federation of Medical Licensing Authorities of Canada.**

Recommendation 24

That the **Regulated Health Professions Act** be amended to include **two levels** of offence of sexual abuse of patients:

I **Sexual Impropriety**, and
II **Sexual Violation**

As defined in this Recommendation.

I. Sexual Impropriety will comprise any behaviour, gestures, or expressions that are seductive or sexually-demeaning to a patient; inappropriate procedures, including, but not limited to, inappropriate disrobing or draping practices that reflect a lack of respect for the patient's privacy or deliberately watching a patient dress or undress instead of providing privacy for disrobing; subjecting a patient to an examination in the presence of medical students or other parties without the explicit written consent of the patient or when consent has been withdrawn; examination or touching of genitals without gloves; inappropriate comments about or to the patient, including, but not limited to, making sexual comments about a patient's body or underclothing; making sexualized or sexually-demeaning comments to a patient; criticism of the patient's sexual orientation (homosexual or heterosexual or bisexual); making comments about potential sexual performance during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction; requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation; making a request to date; initiation by the

physician of conversation regarding the sexual problems, preferences, or fantasies of the physician; and kissing of a sexual nature.

The penalty range for Sexual Impropriety would include reprimand, apology, fine, temporary suspension of licence with conditions or any combination thereof.

II. Sexual Violation will include physician-patient sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may be reasonably interpreted as sexual, including, but not limited to, sexual intercourse, genital to genital contact, oral to genital contact, oral to anal contact, oral to oral contact except Cardiopulmonary Resuscitation, touching breasts or genitals except for the purpose of appropriate physical examination or treatment or where the patient has refused or withdrawn consent, and encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present.

The penalty for Sexual Violation would be a mandatory revocation of licence for a minimum of five years and a fine up to $20,000.00.

That the **Regulated Health Professions Code** should be amended to include the fine and mandatory revocation of licence for five years for members found guilty of Sexual Violation. Once the mandatory five year revocation had been served, the physician would be entitled to apply to the Discipline Committee for reinstatement of his or her licence to practise medicine. The **Regulated Health Professions Code** should be amended so that upon application for reinstatement, the Discipline Committee, the Council or the Executive Committee must require the applicant to fulfill specific requirements including: (see Appendix A for a detailed draft amendment)

- Having the College publish a notice of application which informs all physicians of the intention of the applicant to apply for readmission, and outlines how to contact the College with any relevant information prior to the applicant's readmission hearing.

- Providing a written brief demonstrating the ways in which readmission would be in the public interest.

- Making good all financial losses caused by his or her sexual abuse.

- Filing a statutory declaration setting out in full his or her business or employment activities during the period following revocation of his or her licence.

- Filing a certificate from his or her treating professional detailing the course of treatment entered into and stating the treating professional's opinion of the applicant's compliance with treatment goals and the success of treatment overall.

- Filing a certificate from an independent assessor who has evaluated

the course of treatment and formed an opinion as to its success in ensuring that the applicant poses no danger to future patients.

- Filing a series of documents prepared by the treating professional and the assessor, including an assessment of how the abuse occurred, an outline of specific rehabilitation goals and whether or not they have been met and a list of specific changes in behaviour which have occurred through the rehabilitation process.

- Filing a re-entry plan developed by the independent assessor, which includes substantive safeguards to prevent further sexual impropriety or violation.

- Demonstrating a commitment to ongoing rehabilitation therapy, including submitting quarterly reports to the College on the status of his or her recovery.

In hearing an application for reinstatement, the Discipline Committee would be required to carefully consider each of the aforementioned documents, as well as:

Dr. Eleanor Schumacher at Windsor public hearing of the Task Force, March 24, 1991:

"Doctors are human. We will arrive at a much more realistic assumption about doctors, as society becomes more equitable."

- Testimony from the applicant, the treating professional and the independent assessor as to the applicant's understanding of the harm done by his or her abuse and the effectiveness of rehabilitation in this case, the specific changes in behaviour which have taken place, the commitment to ongoing rehabilitation and specific rehabilitation goals, the proposed safeguards in place should the physician be reinstated, and any practice restrictions including monitoring which are recommended.

Having reviewed all evidence regarding the rehabilitation of the applicant, the Discipline Committee must be convinced that:

- The evidence presented, including expert evidence, satisfies to a substantial degree of medical and psychological certainty that the applicant will not abuse patients or other vulnerable persons in future.

- Re-admission would be in the public interest (see Appendix B for a draft amendment specifying reinstatement criteria).

Recommendation 49

That there be statutory amendments to the **Regulated Health Professions Act** to override the **Statutory Powers Procedures Act** so that the current entitlement of the accused to reasonable information of any allegations should be matched with a requirement on the part of the defence to disclose evidence to be presented.

Recommendation 50

That the section of the proposed **Regulated Health Professions Act** which actually lengthens the time for investigating and presenting a complaint to the Complaints Committee from 60 days to 120 days, be amended to reduce the allowable delay.

Recommendation 51

That the Minister of Health and the Cabinet address the disadvantage created by two-tiered compensation of members on College Councils under the **Regulated Health Professions Act** by immediately increasing the per diem of public members to the same amount received by College members, to be reviewed annually.

Recommendation 52

That the **Regulated Health Professions Act** be amended as follows:

a) to provide that the College can prosecute more than one sexual abuse case together and that Discipline panels may consider together the evidence from more than one complaint;

b) to authorize the Discipline panels to reach decisions without requiring corroboration in sexual abuse cases.

Recommendation 53

That the **Public Hospitals Ac**t, the **Mental Hospitals Act** and the **Private Hospitals Act** be amended to include a **positive obligation** on hospital administration to of complaints about sexual abuse by hospital staff or patients.

a) include in the hospital's annual report (to be forwarded within one month of its release, to the Monitoring Board in Recommendation 1 or its equivalent to be established by the Minister of Health), specific information on safeguards against sexual abuse of patients or staff including a thorough background check before hiring or giving admitting privileges, as well as practices, policies and procedures to prevent sexual abuse, and disposition of any complaints received including the disposition time;

b) maintain the highest possible level of education for themselves and other hospital staff as to the actual damage done by sexual abuse including the likelihood that other patients and sometimes staff are placed at risk when an abuser is not reported and suspended;

c) report to the College the names of all doctors against whom any complaint of sexual abuse has been brought by patients, members of the public, or staff.

That sanctions against inaction on the part of hospital administrators

be developed, including that failure to comply with these obligations be subject to a fine of $5,000.00 to be paid to the Survivors Compensation Fund or its equivalent.

Recommendation 54

That the **Ontario Evidence Act** and the **Regulated Health Professions Act** be amended to create exceptions to the "hearsay rule" to allow statements of **children and vulnerable adults** into evidence, and to use expert witnesses to explain the impact of sexual abuse, utilise devices such as screens, 1-way mirrors and closed-circuit television, to protect those who testify; and the adoption of a code of ethics respecting examination and cross-examination of children and vulnerable adult witnesses.

Recommendation 55

That the **Regulated Health Professions Act** be amended to extend the **privacy protections** found in the Code to patient/complainants or witnesses in sexual abuse cases.

"Some of these doctors are sick; some are confused and some are just bad."
Dr. Carol Nadelson former President, American Psychiatric Association in consultation with the Task Force, March 27, 1991

Recommendation 56

That the **Minister of Health** and the **Treasurer of Ontario** establish a **Survivors Compensation Fund** to receive all monies paid as fines for sexual impropriety or sexual violation. In addition, the doctor must pay into the new Fund the equivalent amount for fees paid by OHIP as "services" when, in fact, the doctor was sexually abusing the patient. As well, proceeds from a levy of 1% of the annual membership fee of the **Ontario Medical Association** (OMA) should be forwarded to the Fund as a clear demonstration by the medical profession of its collective responsibility to patients who have been harmed by a member of the profession. That the procedure for this remedy be established in consultation with the Women's Health Bureau of the Ministry of Health.

Recommendation 57

That the **Limitations Act** be amended immediately in keeping with the March 1991 Report of the Limitations Act Consultation Group so that there will be no limitation period whatsoever on sexual assaults occurring in or as a result of a relationship of authority, trust or dependency.

Recommendation 58

That the Professional Relations Branch of the Ministry of Health immediately provide to members of the **Health Professions Board** substantive training in understanding sexual abuse, similar to that described in Recommendation 27.

Recommendation 59

That the **Director, Public Appointments and Cabinet** immediately

include demonstrated understanding of sexual abuse as an important criterion in the selection of people to sit on the Health Professions Board.

Recommendation 60

That the offence of "aggravated sexual assault" in the **Criminal Code** be amended to include "by a person in a position of trust or authority."



Responding to media questions about the work of the Task Force

This chapter is our attempt to clarify our commentary in the Preliminary Report about many of the changes which the College does not have the authority to make. A great deal of concern has been expressed by many doctors and their lawyers about the impact of our preliminary recommendations on the rights of doctors in the College's disciplinary process. The **Canadian Charter of Rights and Freedoms** (the "Charter"), which is Part I of **Canada's Constitution Act**, 1982, has often been cited as a reason for **not** implementing many of our recommendations.

To date (November, 1991) no court has decided whether or not the disciplinary process of the College is subject to the Charter. Although there was a lower court decision in Ontario in 1985 which found that the Charter applies to the Discipline Committee of the Law Society of Upper Canada, it is not clear whether it will also be applied to the College. (Re Klein and the Law Society of Upper Canada (1985), 50 O.R. (2d) 118 (Ont. Div. Ct.).

The Task Force has been urged to withdraw several of its Preliminary Recommendations so as not to create a "magnet" which will draw Charter scrutiny to the College discipline process. The devastating decision of the Supreme Court of Canada in August of this year, striking down a **Criminal Code** protection for victims of rape in favour of the rights of the accused rapist has caused much concern (Seaboyer and Game, 1991). The Task Force notes that:

1. The Seaboyer decision relates to criminal trials not civil proceedings such as the College conducts.

2. Victims of physician sexual abuse are already subjected to invasive and retraumatizing questions by defence counsel in College hearings (Seaboyer and Game v. R. (unreported decision of the S.C.C., released August 22, 1991).

Just last month, the Supreme Court of Canada in Pearlman confirmed

its previous decision in Wigglesworth (1987) that the criminal law protections for the accused in section 11 of the Charter are not available to an accused professional in a civil disciplinary proceeding. Nevertheless, there are other sections of the Charter which may eventually be applied to protect the constitutional rights of both the patient/complainant and the doctor. For this reason, the Task Force has responded to the onslaught of concerns about our Preliminary Recommendations by subjecting them to an external evaluation, which is contained in the Legal Appendix following this chapter. (R. v. Wigglesworth [1987] 2 S.C.R. 541; 81 N.R. 161; Pearlman v. Manitoba Law Society Judicial Committee (unreported decision of the S.C.C., released September 26, 1991).

Through Legal Round Tables and other consultations, the Task Force canvassed a wide range of perspectives before making our Final Recommendations. We make them because we are convinced that they must be fully implemented - in essence - if a new balance with greater equity between doctor and patient is to be achieved.

Recommendation 24 - Defining Sexual Abuse: I. Sexual Impropriety II. Sexual Violation

The **Health Disciplines Act** is currently the primary source of jurisdiction under which the College conducts its disciplinary hearings. However, the **Health Disciplines Act** is soon to be replaced by the **Regulated Health Professions Act**, (RHPA). The RHPA perpetuates the absence of a definition of "sexual impropriety" as a form of "professional misconduct" which in the opinion of the Task Force has had the effect of trivializing the damage done to patients who are sexually abused. Both the Discipline Committee at the College and the Courts have had difficulty understanding the serious impact sexual abuse has on patients. This has meant that the Discipline Committee has dismissed charges in some cases (for example, the "pelvic bonding" decision in the Fall of 1990), and in others, the Divisional Court has reduced the penalty imposed by the Discipline Committee of the College because sexual impropriety is not seen as a serious breach of professional standards. It would appear that judges identify very strongly on a personal basis with doctors in these cases. They seem to be easily persuaded by defence counsel that revocation of a doctor's licence is equivalent to "capital punishment." Little or no consideration is given to the lifelong sentence meted out to many victims of sexual abuse by doctors or the risk of harm to the abusing doctor's other patients. Clearly, education for judges and lawyers is a pressing need.

We are recommending that the **Regulated Health Professions Code and Regulations** contain a new definition of sexual abuse which is much more specific and consists of two levels for the purpose of determining the penalty. Once the Discipline Committee has reviewed the evidence in a particular case and found the doctor guilty of either level I of the offence, Sexual Impropriety, or level II of the offence, Sexual Violation, that determines what penalty options the Discipline Committee may impose on the doctor. We are recommending a mandatory penalty to imposed after the Discipline Committee has found a doctor guilty of the second level - Sexual

Violation - with automatic revocation of the doctor's licence for 5 years as well as a fine of up to $20,000. We have also recommended that the RHPA Code be amended to require the College to apply specific reinstatement criteria when a doctor found guilty of either Sexual Impropriety or Sexual Violation applies to have a suspension lifted or a licence reinstated.

Many doctors and their lawyers have objected to Recommendation 24 on the grounds that the penalty will infringe Section 7 rights of the Charter or that such a severe penalty goes against the "principles of fundamental justice." The Task Force has responded in considerable detail to these concerns in the Legal Appendix following this chapter. In summary, the trend in the caselaw is against recognizing that a "right to work" or a "right to practise" one's profession is protected by Section 7 of the Charter. Although the Supreme Court of Canada has not made a clear decision on this issue, the Ontario Court of Appeal has stated that:



Participants in the Task Force' Legal Round Table held in June 1991

> "there is no constitutional right to practise medicine."
> Re Jamorski (1988), 64 O.R.(2d) 161 at 168

Comments by Chief Justice Lamer in the Prostitution Reference (ss. 193 and 195.1(1)(c) of the **Criminal Code** (1990), 109 N.R. 81 (S.C.C.) at 143) suggest that the Supreme Court is likely to define Section 7 narrowly, rather than allowing Section 7 claims based on non-physical matters such as dignity and reputation. If this trend becomes a reality, it will be unlikely that professionals appearing before disciplinary tribunals will be able to maintain successfully that their rights to life, liberty and security of the person are being infringed upon by procedural rules recommended by this Task Force.

Civil Standard of Proof

In our Preliminary Report, we expressed concern that the test for evidence used by College investigators and adjudicators should not be the criminal standard, i.e. beyond a reasonable doubt. The standard of proof is an attempt to articulate in abstract terms a highly ambiguous and complex mental threshold which exists in the mind of a trier of fact. If a panel of the Discipline Committee or an appellate court feels that there is insufficient credible evidence to support a serious allegation of sexual abuse, it will find that the prosecution failed to meet the standard of proof regardless of how the standard is actually defined. As a result of the Bernstein decision in 1977, the civil standard of proof generally considered appropriate for professional disciplinary hearings is on a "sliding scale," as explained by the Ontario Court of Appeal: "the more serious the allegation to be proved, the more cogent must be the evidence." (Board of Ophthalmic Dispensers v.

Toth [1990] O.J. No. 1802, File No. 102/88(C.A.) The impact of the "sliding scale of proof" seems to have created an evidentiary standard described to us by some Discipline Committee members as "almost beyond a reasonable doubt" in sexual abuse cases and we have concluded that the College should clarify with its adjudicators that the criminal standard of proof must not be applied.

Recognizing that our proposal to enact a legislative requirement that Discipline panels must apply the civil standard of a "bare balance of probabilities" as the only standard in disciplinary proceedings is not likely to be effective, the Task Force has decided to focus on how the standard of proof is applied in individual cases. Our legal research has led us to conclude that this approach will provide a more effective means of achieving the desired goal of improved enforcement of the College's prohibitions on sexual abuse by physicians. Not only will this approach avoid some of the legal difficulties outlined above, but more importantly, it may provide a more effective means of achieving the desired goal of improved enforcement of the College's prohibitions against sexual abuse by physicians. The jurisprudence suggests that two evidentiary factors have the greatest impact on the application of the sliding civil standard. It would seem that tribunals are most likely to render a finding of not guilty (a) where a physician denies the conduct and offers evidence as to good character in the community; and (b) where there is a lack of corroboration for the complaint.

Applying the Civil Standard of Proof for Character Evidence

In R. v. Millar, the Court of Appeal held that evidence of good character can serve two purposes: (a) as the basis of an inference that the accused is unlikely to have committed the crime charged, and (b) to support the credibility of the accused. In the decisions to date, it is difficult to ascertain whether the Discipline Committee employs evidence of good character as tendered by doctors for both of these purposes or for one rather than the other. (R. v. Millar (1989), 49 C.C.C. (3d) 193 (Ont. C.A.)).

Recommendation 44 may effectively counter the first use of character evidence identified in Millar, i.e. the use of good character evidence as an indication of a lack of propensity for the accused to commit the offence in question. The Task Force acknowledges that defence counsel will continue to attempt to use good character evidence to support the general credibility of the accused doctor before the Discipline panel. This acknowledgement supports Recommendation 32 which is geared to lessening the extent to which an all-male panel with a majority of doctors will be influenced by the demeanour of a colleague.

Corroboration

A review of decisions reveals that panels are unlikely to find a physician guilty where there is a lack of corroboration for the complaint. The Bernstein decision is again the source of much influence in the attitudes of

adjudicators in sexual abuse cases.

In practical terms, corroboration requires evidence, other than the word of the patient/complainant, which confirms or verifies through some external supporting information that her allegations are founded in fact. For a more complete discussion please refer to Chapter 10, paragraph 15 of the Legal Appendix.

Sexual abuse of a patient by a physician is a very private act. As long as adjudicators require external confirming evidence and approach complainants of sexual abuse with a prejudice which is often unconscious, it is unlikely that the standards implicit in the philosophy of **Zero Tolerance** can be achieved. The 'de facto' requirement of corroboration is enabling abusers to continue and to repeat the abuse. No Ontario court has explicitly ruled against an adjudicator relying on the evidence of the patient/complainant alone. However, the attempt in 1985 by Madame Justice Van Camp in the CPSO v. K (1985), 50 O.R. (2d) 14 (Div. Ct.) decision to move away from the need for corroboration in sexual abuse cases has not been followed.

The Task Force has included a new Recommendation 52 which proposes a legislative amendment to expressly authorize a Discipline panel to make a finding of guilt in sexual abuse cases, without corroboration. It is important to send a clear signal to appellate courts to exercise greater deference in reviewing the findings of Discipline panels in sexual abuse cases.

Mutual Disclosure

In civil proceedings, both parties have to participate in examinations for discovery, and provide disclosure to the other party. In criminal proceedings, the Crown has to prove the case against the accused, and the accused is not required to volunteer any information. However, in reality, pre-trial conferences are held to deal with the administrative and legal issues. The College conducts its disciplinary hearings as an administrative tribunal not as a criminal court, so criminal rules of procedure should not be followed.

Presently, Section 12 (2) of the **Health Disciplines Act** requires disclosure of the prosecution of any document or written material which will be given in evidence at the hearing. However, there is no statutory obligation for the defence to disclose anything to the prosecution. This one-sided disclosure leads to significant inefficiencies and injustice. So far, proposals to require a pre-hearing conference in front of a member of the Discipline Committee have been vigorously opposed by the defence. The Task Force sees no reason, in law, or in the interest of fairness, that this should be allowed to continue at the College. We are recommending that the College immediately modify its current practice and require a pre-hearing procedure similar to that employed by the Pay Equity Tribunal and the Ontario Human Rights Commission, and that the fullest possible disclosure of information from all parties be required immediately. The Task Force is also recommending that there be a statutory amendment to the **Health Disciplines Act** (or its proposed successor, the **Regulated Health Professions Act**) and the **Statutory Powers Procedure Act** (see later discussion in this Chapter),

that would require mutual disclosure of information in disciplinary hearings.

Delay as Injustice

We have concluded that the section of the proposed **Regulated Health Professions Act** which lengthens the time for investigating and presenting a complaint to the Complaints Committee from 60 days to 120 days is unacceptable. The College has demonstrated already that sexual abuse cases can be presented to the Complaints Committee in less than 120 days.

Unfortunately, there have been substantial delays in prosecuting cases once they have been referred from the Complaints Committee to the Discipline Committee. Delays of more than one year are common, apparently because the Discipline Committee has developed a serious backlog of cases. This systemic delay is unfortunate for three reasons:



Pat Marshall thanks a presenter for participating in a public hearing

1. The Supreme Court of Canada's decision in Askov has set a standard in criminal cases, which may provide a basis for a doctor to challenge the prosecution of his case because his Charter Section 7 rights have been infringed.

2. Lengthy delays are difficult for the doctor, the complainant and other witnesses. Memories fade and evidence becomes more difficult to obtain.

3. Testimony to the Task Force and a review of the American research point to the likelihood that, if one patient has been sexually exploited, other patients of the abuser may well be at risk.

Increased Public Representation on Council

The proposed **Regulated Health Professions Act** anticipates a significant increase in the numbers of members of the public who sit on councils of Colleges. We fully support this proposal. However, the Minister of Health needs to address the disadvantage created by a two-tiered membership on councils. As a result of paying public members only $125.00 per day compared to the per diems paid to occupational members by the respective Colleges (such as $655.00 per day for physicians) the Government is missing the opportunity to enhance the expertise available to serve the public interest. Under the present arrangement, significant financial loss must be absorbed by many of the public members who serve on the Discipline Committee and this must not be allowed to continue.

Criteria for public members should be established by the Minister of Health, including the availability to devote considerable time to serving on either Complaints or Discipline panels. At the present time, the College is hampered in its attempts to reduce the backlog of discipline cases because not enough public members are able to dedicate the extensive time needed to participate on the Discipline Committee panels.

Recruiting Public Members Skilled in Adjudication

In two recent cases (Re: Agnew, about discipline of an architect and Re: Khan, discipline of a doctor), the Divisional Court sharply criticized the practice of retaining counsel to the Discipline Committee to give legal advice on issues arising during the hearing, and to assist in drafting reasons for the Committee's decision.

At present, the Discipline Committee appears to be in a "no win" situation. Members are chosen because they are peers of the doctor in a self-regulating profession, or because they are members of the public chosen to represent the public interest. No one is chosen because of legal expertise. In sexual abuse complaints, as well as other cases, it would be a sensible move to recruit lawyers, with experience in legal rulings and writing reasons to sit as public members of the council and to serve on the Discipline Committee. The majority of public members recruited should be women, including those with prior experience in adjudicating. Obviously, recruiting individuals with this expertise will be virtually impossible as long as public members of the Council are reimbursed at the current rate.

The College needs to embark on a dedicated recruitment of women doctors to run for election to its Council (and to win!) Only 2 of the 21 doctors on council are women. None of the 5 University representatives are women.

Evidentiary Framework in Anticipation of Appeals to the Divisional Court

Sadly, there is little evidence that judges in Ontario are demonstrating a desire or an ability to respond to the reality particular to victims of sexual abuse.

A review of ten College decisions which have been appealed would seem to indicate that the Divisional Court has overturned CPSO decisions more often than those of other health disciplines. For example, in two appeals from decisions by the College of Nurses, the Court said that it would be "extraordinary" to interfere with the findings of the Discipline Committee of the College of Nurses (Singh and Riddell). Yet, in only five of the ten CPSO cases did the Court uphold the decision of the Discipline Committee. In three of the cases, the finding of "guilty" was overruled by the Court, and in two of the cases, the penalty was reduced by the Court. Once again, the judicial identification with the doctor may well be a strong factor resulting in a lack of understanding of the damage actually done by sexual abuse.

and perhaps, a devaluation of the "punishment" for victims of sexual abuse as compared to the doctor's punishment.

As a practical means of changing judicial attitudes, and therefore, judicial decisions about sexual abuse by doctors, we are recommending that evidence related to risk of harm to other patients, actual damage to the abused patient, the high probability of recidivism and professional scepticism about actual rehabilitation being possible must be presented in every sexual abuse case at the College. Then, if appealed, this information will be on the record reviewed by the Court. The College has an opportunity and a responsibility to put before the courts as much information as exists to demonstrate that a dramatic shift in understanding is needed if justice is to be served. Until it is clear that there is no **risk of harm**, the public should not be placed at risk.

Amendments to Other Statutes

"We submit that other steps should be taken to protect children and vulnerable adults in the hearing process. These would include the use of expert witnesses to address the issue of sexual abuse; the use of devices such as screens, 1-way mirrors and closed-circuit television, to protect those who testify; and the adoption of a code of ethics respecting examination and cross-examination of child and vulnerable adult witnesses."

Willson A. McTavish, Official Guardian of Ontario, Written Communication to the Task Force, July, 1991

The Task Force has received testimony about a disturbing number of cases in which hospital administrators have acted as "enablers" to abusing doctors, going so far in several cases as to threaten or to fire other staff members (not doctors) who have attempted to raise the issue of the abuse within the hospital setting. Based on this testimony, Recommendation 53 proposes that hospitals must assume a positive obligation on their administration to:

a) be vigilant as to any possibility of sexual abuse of patients or staff within the hospital;

b) maintain the highest possible level of education for themselves and other hospital staff as to the actual damage done by sexual abuse including the likelihood that other patients are placed at risk when an abuser is not reported and suspended; and

c) report to the Colleges the names of all regulated health professionals, including doctors, against whom any complaint of sexual abuse has been brought by patients, members of the public or by staff.

Open/Closed Hearings

The enactment of the **Regulated Health Professions Act** will confirm the trend of professional disciplinary hearings becoming more open to the public. The RHPA Code requires that a hearing shall be open to the public, with certain exceptions, and gives to the Discipline panel the authority to "make orders it considers necessary to prevent public disclosure ...including orders banning the publication or broadcasting of those matters." As well, the Code allows a witness in sexual misconduct hearings to request the Discipline panel to "make an order that no person shall publish the identity of the witness or any information that could disclose the identity of the witness."

Currently, Section 9 of the **Statutory Powers Procedure Act** does not seem to take into account the unfairness of excluding a complainant witness from a closed hearing. If the doctor is present to hear the complainant's evidence, then the complainant must have the option to hear the doctor's evidence, and to receive transcripts and other documents from the closed proceeding. We are aware of the current review of the **Statutory Powers Procedure Act** and we are recommending that the **Regulated Health Professions Act** provisions for open hearings be amended to override the **Statutory Powers Procedure Act** to ensure a complainant witness is not excluded from a closed hearing.

Children

Although there is no need to have evidence to corroborate the evidence of an adult complainant, the Discipline Committee cannot convict on the basis of a child's unsworn evidence, unless it is corroborated. In recent decisions, particularly the Khan decision, the courts have imposed a very legalistic framework on such cases. It is not surprising that a Discipline Committee, with no legally trained members, would have difficulty drafting its reasons to meet this standard. The Task Force is recommending that training on issues of children's evidence be included in the educational joint venture with the Law Society of Upper Canada and that the July 1991 report of the Ontario Law Reform Commission on Child Witnesses be included in the curriculum (Recommendation 6). We are recommending that the RHPA be amended to allow the protections recommended by the Official Guardian in his written communication to the Task Force. As well, we are recommending further study of amendments to the Ontario Evidence Act allowing third-party experts to give the child's evidence at the hearing. If we are not prepared to minimize the damage done to children through our legal processes, then the Task Force recommends that there be no pretence that it is possible to fairly prosecute sexual abuse cases involving children.



Legal counsel for the College, Julian Porter, was one of the many lawyers who took part in the Task Force's Legal Round Table

Concerns about the Regulated Health Professions Act

The current **Health Disciplines Act** is being replaced by the **Regulated Health Professions Act** (RHPA). The Task Force presented a summary of the concerns outlined in this chapter to the Standing Committee on Social Development in August, 1991, following the release of our Preliminary Report. At that time, we made this statement:

> "We are before you today to deliver one primary message: patients who have been sexually abused have been almost entirely left out of the equation which is the proposed **Regulated Health Professions Act** (RHPA).
>
> It would be tragic and unjust if the resources of this Legislature mobilised at such legitimate expense now failed to reflect the basic premise of **Zero Tolerance**.
>
> Patients who have been sexually abused by health professionals need to be factored into the equation - into the balance of rights - of this statute."

In both Acts, it is the duty of the Minister to ensure that the health professions are regulated and coordinated in the public interest. However, the proposed Act expands the power of the Minister to "**require** a Council to make, amend or revoke a regulation under a health profession Act ..." and to:

> "**require** a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, ..."

The proposed Act also establishes a new Health Professions Regulatory Advisory Council with duties which include advising the Minister on "whether regulated professions should no longer be regulated." The proposed Act indicates that "the Minister shall refer to the Advisory Council any issue within its duties that a Council or person requests the Minister to refer ..."

At the time of writing this Report, the Government of Ontario is finalizing the RHPA. When this proposed Act becomes law, the College of Physicians and Surgeons will then be governed by the same set of rules in the RHPA Code as all the other health professions under the Act. Following are some areas of concern which we have with the **Regulated Health Professions Act**.

Barriers to Filing A Complaint under the proposed Act

We recommend that the requirement that a complaint must be in writing before a Complaints panel will be constituted be amended to allow for the reality of disabled people who need to be able to submit their complaint in alternative forms, such as on a tape recording. The College should also be required to provide an appropriately trained interpreter or translations as required by patients.

Greater Participation for the Patient in Complaints Hearings

We recommend that the proposed Act not perpetuate the effective discrimination of the existing Act which limits the participation of the patient

complainant severely. A significant number of complainants have reported to the Task Force that they would never have subjected themselves to the process, had they known how debilitating it was going to be.

Access to medical files

This Act should be amended to clearly guarantee to each patient access to all medical records and files pertaining to that patient. Access to these files must not be left to the discretion of a College in the course of a hearing.

Decreasing the Delay in Processing Complaints

The proposed Act extends the initial time allowed before the Complaints Committee makes a decision to 180 days (6 months). This is longer than it currently takes the College to investigate and bring a sex abuse complaint to the Complaints Committee. We recommend that this be reviewed and the time reduced to a total of 120 days, after which the College should have to apply, with reasons, for an extension.

Public Members on the Discipline Committee

The wording in the RHPA Code does not place a maximum on the number of members (public or occupational) on the Discipline Committee and we support this. At least two of the members of each Discipline panel should be public members. This allows a number of three or five person panels to be composed from the Discipline Committee so as to reduce the backlog and reduce the strain on members of the Discipline Committee.

We recommend that the Code be amended to require that the public member must be present throughout the hearing process and the decision-making, not just "for a hearing to commence."

Prejudice to the Patient Complainant

Several sections of the RHPA Code focus on preventing prejudice to the member of the health profession who has been charged. While we support developing a process that is fair both to the patient and the doctor, we are very concerned that the proposed legislation continues to allow systemic discrimination against patients. For example, the Code should be reviewed in light of research now available about post traumatic stress disorder. This rule that the description of allegations can only be amended to correct errors or omissions "of a minor or clerical nature" does not allow a victim of sexual abuse whose memory returns unpredictably and often in a disorganized series to place before the decision-makers all of the relevant information in time to be considered. Also, the Act needs to be reviewed in light of the emphasis on only disclosure to the defence thereby giving no opportunity in advance of the hearing to the College or to the patient to prepare for the defence. Many administrative tribunals allow for disclosure on both

sides and this Code should also. Similarly, the code should allow for copies of a transcript of the hearing to be made available to the patient where the patient is not a party.

Patient as a Party to the Hearing

We strongly support the option in the RHPA Code which allows a panel of members of the Fitness to Practise Committee to specify "any person" as a party to a hearing on the issue of incapacity, as well as the College and the member of the College (physician) being parties. We recommend that this option be given to panels of both the Complaints Committee and the Discipline Committee. At a minimum, we recommend a guarantee of Intervenor status as per Recommendation 42 in our Preliminary Report, and we believe the RHPA Code sets a positive precedent.



Roz Roach, a psychotherapist and Task Force member, speaking at a public hearing

Survivors Compensation Fund

In a number of sections, the Code anticipates payment of fines to the Treasurer of Ontario. One of the more disturbing realisations we have had based on testimony presented to the Task Force, is that abusing doctors have far too often continued to bill OHIP for the time spent sexually exploiting their patients. Recovery from sexual abuse by doctors is often enormously difficult, requiring very specialized care which is seldom readily available and seldom funded by OHIP, the provincial health care fund.

So that the perpetrators of sexual abuse do not continue to profit from their offences, and so that the victims have access to a more meaningful remedy than just a finding of "guilty", we recommend that the Treasurer of Ontario, in consultation with the Minister of Health, determine the most appropriate way for all monies paid as a result of fines for Sexual Impropriety or Sexual Violation to go into the Fund. In addition, the doctor must pay into the Survivors Compensation Fund the equivalent amount of fees paid by OHIP as "services" when in fact the doctor was sexually abusing the patient. Patients whose doctors have been found guilty of Impropriety or Violation may then apply for financial assistance in their attempts to recover from the harm done to them. We recommend that the procedure for obtaining this remedy be established in consultation with the **Women's Health Bureau** of the Ministry of Health.

In keeping with the above proposal, we also recommend that the RHPA Code be amended to include a fine of not more than $20,000.00 as one of the orders that can be made by a Discipline panel as a penalty for incompetence, due to sexual impropriety or sexual violation of a patient.

No Stay of Order Against Doctor Found Guilty of Sexual Impropriety or Sexual Violation

We recommend that the RHPA Code include sexual violation as a ground of incompetence or incapacity. It is very important for there to be recognition of the serious harm done to patients who are sexually abused by their doctors as well as the likely risk of harm to other patients of a sexually abusing doctor in all possible applications of the RHPA Code rather than as "just misconduct."

Limitation Period

The one-year limitation period limiting a doctor's liability to any action arising out of negligence or malpractice is grossly unfair to survivors of sexual abuse. Based on the information now available about post traumatic stress disorders, there must be specific attention paid to the reality that sexual abuse survivors do not always report quickly. The recommendations of the Report of the Limitations Act Consultation Group to the Attorney-General (March 1991) recognise that "in some circumstances the sexual assault will render the victim incapable of considering legal proceedings until many years after the event. These circumstances typically involve victims who were in a relationship of trust or dependency ... many years of therapy may be required before the victim is able to confront the assailant. Where a victim was also physically, mentally, or psychologically disabled at the time of the assault, another incapacitating factor is added."

We recommend that the RHPA Code follow this Report and establish that there will be no limitation period whatsoever on sexual assaults occurring in or as a result of a relationship of authority, trust or dependency, in particular with any health care professional.

Legal Appendix

LEGAL APPENDIX

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LEGAL APPENDIX

INTRODUCTION

As discussed in the Acknowledgement in the Final Report of the Task Force, a team of students made available to the Task Force by Osler, Hoskin & Harcourt examined many of the Preliminary Recommendations from a legal perspective. The views of a number of distinguished lawyers named in the Acknowledgements were also reviewed. This was prompted by a desire on the part of the Task Force to ensure that its Final Recommendations respect rights and freedoms which are enshrined in the Charter of Rights and Freedoms. This Appendix is the product of this process.

The first chapter examines some of the legal policies which support the case for more effective regulation of the doctor-patient relationship. The second chapter, which considers the threshold question whether the Charter of Rights will apply to measures which implement the Task Force Recommendations, suggests that it is more likely than not that the Charter will indeed apply.

The Charter is a constitutional document. As such, it takes precedence over any statutes, regulations or administrative decisions, rules and policies which are inconsistent with it.

It should be noted that the various rights and freedoms in the Charter are not absolute. Instead, section 1 of the Charter provides that they are subject to "reasonable limits" which are "prescribed by law" and "demonstrably justified" in a "free and democratic society". It is only if a particular legislative or administrative action violates a right or freedom and is not "demonstrably justified" under s. 1 that it will be viewed as being inconsistent with the Charter and thus invalid.

Therefore, although the Charter will likely apply to instruments which implement the Recommendations, the question whether the Charter can be successfully invoked to invalidate an implemented Recommendation is an entirely different question. As can be seen in chapters 3 to 10, legal arguments exist in support of the view that many of the Recommendations, if implemented, would not infringe the rights and freedoms set out in the Charter. Further, there are a number of legal arguments which support the view that any infringements of Charter rights and freedoms are "demonstrably justified" under section 1 of the Charter. This examination of arguments concerning justification is contained in chapter 11.

We would again like to acknowledge Osler, Hoskin's team of students for their important contribution to the work of the Task Force and to express our gratitude to Osler, Hoskin for extending their students' services to us on a pro bono basis.

CHAPTER 1 - THE CASE FOR REGULATION: LEGAL POLICIES

INEQUALITY OF POWER

1. The legal policies which bear upon the doctor/patient relationship has implications for almost all of the Task Force's Recommendations. The relationship may be the basis for civil action which could coincide with Complaints and Disciplinary proceedings. Furthermore, the power dynamics of the relationship and the severity of the breach of trust involved in a particular case are important considerations when dealing with the proper penalties for sexual violation and impropriety. And finally, the nature of the doctor/patient relationship may have important implications for balancing the rights of the parties under s. 1 of the Charter. Accordingly, the Task Force considers it appropriate that the legal policies underlying the case in favour of regulation of the doctor/patient relationship be examined.

2. Generally, the doctor/patient relationship is one where an imbalance of power exists - patients come to doctors when they need their skill and knowledge. They place their physical and mental well-being in the hands of doctors and trust them to act in the patient's best interest. Doctors occupy a privileged position in society on the basis of their education, status and access to resources. Very rarely will the patient be on an "equal footing" with his or her doctor - the patient's need for something only a doctor can provide automatically introduces an element of vulnerability.

3. This power imbalance is exacerbated when the doctor/patient roles are combined with certain other factors relating to the personal characteristics of the parties. For example, an adult doctor and a child patient have a relationship with an even greater element of vulnerability present. The same may be argued for other groups in society, such as the handicapped and visible minorities, etc. Since the overwhelming majority of sexual abuse/impropriety cases involve female patients and male doctors, the gender dynamic cannot be ignored. Professor Kathleen Morgan has argued that the stereotypical norms of behaviour for males and females throughout society correlate to the paternalistic model of doctor/patient relationships.

> K. Morgan, Philosophical Analysis: Permissibility of Sexual Contact Between Physicians and Patients (Part III) - Department of Philosophy and Centre for Bioethics, University of Toronto.

4. Canadian law in other contexts recognizes that many relationships involve inequality of power and provides special remedies to redress that imbalance in certain situations. Such remedies include:

   I. the doctrines of duress, undue influence and unconscionability, which provide relief in contractual matters;

   II. statutory provisions designed to protect the weaker party in certain institutional relationships e.g. consumers, employees, tenants, children;

III. recognition in the Criminal Code (s. 265(3)(d)) that exercise of authority can invalidate any "consent" as much as threats of physical violence;

IV. recognition in tort law that the defence of consent may be invalidated where the consent was obtained through duress, undue influence, or misrepresentation as to the nature and effect of the act; and

V. the law of fiduciary relationships.

5. To the extent that the doctor/patient relationship can be said to be one of contract, the first category of remedies may apply in certain circumstances (i.e. - a patient may want to vitiate a contract for medical services not covered by OHIP)

> Norberg v. Wynrib (1988), 27 B.C.L.R. (2d) 240, affirmed (1990), 44 B.C.L.R. (2d) 47 (B.C.C.A.) (appeal to the Supreme Court of Canada heard and decision reserved June 19, 1991)

6. To the extent that the patient is a consumer of a service, the statutory recognition of this imbalance of power may also apply.

> Ontario Human Rights Code, 1981 S.O. 1981, c. 53 as amended, s. 6(3).

7. The law of informed consent in relation to medical treatment also recognizes that the degree of power exercised by a doctor over a patient may affect the nature of any consent given.

> L.E. Rozovsky, The Canadian Law of Consent to Treatment (1990, Butterworths Canada Ltd., Toronto)
> Denise LeBoeuf, "Psychiatric Malpractice: Exploitation of Women Patients," (1988), 11 Harvard Women's Law Journal 83-116.

8. Perhaps the strongest basis for challenging a doctor who has taken advantage of an unequal relationship lies in the law of fiduciary relationships. If a fiduciary duty exists, then breach of that duty is an independent basis for civil liability. The extent to which the doctor/patient relationship is fiduciary in nature remains an open issue. Nevertheless, the policies underlying the protection of fiduciary relationships seem equally applicable to aspects of the doctor/patient relationship.

> METRAC, Breach of Trust in Sexual Assault: Part One - Review of Canadian Sentencing Decisions (1990, Toronto).

9. The fiduciary relationship has been defined as follows:

> "Where a fiduciary relationship exists, the fiduciary has a paramount duty of loyalty. A fiduciary cannot permit a conflict between the interest of his beneficiary and any other interest, especially his own. A fiduciary may not obtain a profit, benefit, or advantage as a result of his position".
>
> Ontex Resources Ltd. v Metalore Resources Ltd. (1991), 75 O.R. (2d) 540 (Ont. H.C.) at p. 553.

10. Traditionally, the law of fiduciary duties has evolved around the law of trusts. However, in Canada the concept of fiduciary duties has expanded in recent years to encompass many new areas beyond trust. In fact, the Supreme Court of Canada has made it clear that the traditional categories of fiduciary relationships are not closed.

> Lac Minerals Ltd. v International Corona Resources Ltd., [1989] 2 S.C.R. 574 (1989), 61 D.L.R. (412) 14
> Guerin v. the Queen [1984] 2 S.C.R. 335 at pp. 383-84, per Dickson C.J.C. (as he then was)

11. In Lac, at pp. 598-600 (S.C.R.); pp 62-63 (D.L.R.) the Supreme Court approved of Wilson J.'s "rough and ready" guide for establishing when a fiduciary duty exists:

> 1. The fiduciary has scope for the exercise of some discretion or power.
>
> 2. The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests.
>
> 3. The beneficiary is particularly vulnerable to or at the mercy of the fiduciary holding the discretion of power.
>
> Frame v. Smith (1987), 42 D.L.R. (4th) 81 at (S.C.C.) pp. 98-99.

12. In Frame, Wilson J. (dissenting), found a fiduciary duty between parents in a custody dispute. While noting that fiduciary duties have traditionally been found only in economic or property contexts, she explicitly allowed for protection of non-economic interests as well:

> To deny relief because of the nature of the interest involved, to afford protection to material interests but not to human and personal interests would, it seems to me, be arbitrary in the extreme. (at 104).

13. Similarly, in a recent decision of the Ontario Court of Appeal, a fiduciary duty between lawyer and client was found to have been breached when the lawyer used his knowledge of

the client's personal life to seduce his client's wife - clearly a case where the courts protected non-economic interests.

> Szorfer v Chodos (1988), 66 O.R. 350 (Ont. C.A.)

14. The "vulnerability" aspect of Wilson's test was explored by the court in Lac. As Donovan Waters notes in his comment on Lac

> "the vulnerability is not so much to the infliction of harm...but to abuse of the power or discretion...Vulnerability is a third element, but in the sense of being a consequence of power or discretion in one party, and the unavoidable reliance of the other party upon the integrity of the exercise of that power or discretion."
>
> Donovan Waters, "Case Note" (1990), 69 Can. Bar. Rev. - at pp. 475-476.

15. Applying the above test to the doctor/patient relationship, it is arguable that a fiduciary duty exists at least in some aspects of the relationship. The doctor has tremendous power and discretion over the patient's treatment, which he or she can choose to exercise in a way that affects the patient's well-being (i.e. by sexual violation or impropriety) and the patient is extremely vulnerable to such an abuse of power.

16. In the recent case of Norberg v. Wynrib, a young woman addicted to pain killers admitted her addiction to her doctor, after which the doctor supplied her with drugs on the condition that she comply with his sexual demands. The patient later sued the doctor alleging assault, negligence and breach of fiduciary duty. The trial judge found a clear breach of fiduciary duty.

> Regardless the nature of their relationship, it is clear that a physician has a duty to act in utmost good faith towards a patient. It is trite to say that a physician must never allow his personal interests to conflict with his professional duty. In this case, Dr. Wynrib clearly did this. He was legally and ethically bound to treat his patient's drug addiction or to refer her to a drug rehabilitation centre. He did neither. Rather, he capitalized on her addiction. He showed a total disregard for the best interests of his patient.
>
> Norberg v. Wynrib supra at p. 246

17. The majority of the B.C.C.A. expressly adopted the above statement (at p. 198). However, McEachern C.J.B.C., for the majority, did not agree that the breach of duty should be characterized as breach of fiduciary duty, because the breach did not relate to "an improper disclosure of confidential information or something like that" (at p. 198).

With respect, this is a misinterpretation of the Lac case. The S.C.C. decision in Lac makes it clear that disclosure of confidential information is not necessary to find breach of fiduciary duty - in fact, breach of confidence is a separate cause of action, which may or may not coincide with the breach of fiduciary duty.

18. Locke J.A., dissenting in Norberg v. Wynrib, discusses some of the old authorities which have asserted a fiduciary relationship between doctor and patient, and finds that the "fiduciary" label was misapplied to situations which were really breach of confidence. Given the S.C.C.'s decision in Lac, the Task Force believes that Locke J.A.'s analysis is probably correct, and little weight should be given to these old authorities.

> Kenny v. Lockwood, [1932] O.R. 141 (Ont. C.A.)
> Henderson v. Johnston, [1956] O.R. 789 (Ont. H.C.).
> Mark Ellis, Fiduciary Duties in Canada (1988), at para. 10:19
> Dennis Klinck, "Things of Confidence" (1990), 54 Sask. L.R. 97

19. The Norberg v. Wynrib case was heard by the Supreme Court of Canada on June 19, 1991 and it reserved its decision. The release of this decision is almost certain to be determinative of this issue, and may provide patients with added protection against the power imbalance inherent in the doctor-patient relationship.

CHAPTER 2 - CHARTER APPLICABILITY

1. Before an examination of the Recommendations and the various provisions of the Charter of Rights is conducted, it is first important to consider whether the Charter of Rights will apply to measures which implement the Recommendations. We shall consider this issue in this chapter.

2. The Canadian Charter of Rights and Freedoms, (the "Charter") only applies if one of the parties to litigation is "government" or if one of the parties is challenging "government action". Therefore, the Charter will apply to the actions of the Council and Discipline Committee of the CPSO if it is found that the College is either part of "government" or that the College in enacting its policies is carrying out "governmental action".

R.W.D.S.U. v. Dolphin Delivery, [1986] 2 S.C.R. 573

3. In Dolphin Delivery the Supreme Court stated that the legislative, administrative and executive branches of government are subject to Charter scrutiny. The Supreme Court has had the opportunity to consider the meaning of the notion of "government" under s. 32(1) of the Charter in the following quartet of recent cases:

(1) McKinney v. University of Guelph (1990), 14 O.A.C. 1 (S.C.C.);

(2) Douglas/Kwantlen Faculty Association v. Douglas College (1990), 118 N.R. 340 (S.C.C.);

(3) Stoffman v. Vancouver General Hospital (1990), 118 N.R. 254 (S.C.C.); and

(4) Lavigne v. O.P.S.E.U. (1991), 81 D.L.R. (4th) 545 (S.C.C.)

The majority of the Supreme Court in all four cases focused on whether the entities involved were part of the administrative branch of government. McKinney and Stoffman decided that the particular universities and hospitals considered in those cases were not "government emanations". Douglas and Lavigne confirmed that the community colleges in issue in those cases were.

4. In McKinney the Supreme Court dealt with the challenge to the mandatory retirement provisions contained in the policies of four Ontario universities. Writing for the majority, La Forest J. made it clear that the mere fact that an entity is incorporated and performs an important public service does not establish that its actions fall within the ambit of the Charter. The majority held that universities in issue in the case should not be considered part of government even though they are established by statute and are largely government funded, because they are essentially autonomous bodies. It would appear that in order to meet the definition of "government" under the Charter, the majority in McKinney would require that the entity would have to be under general governmental control and the alleged

violation of the Charter would have to result from a policy or policies that were subject to such governmental control.

McKinney, supra, at pp. 642-643

5. A minority of the Supreme Court in McKinney followed a more definitive test for deciding whether an entity is part of government. The test as set out by Wilson, J. asks the following three questions:

   1. Does the legislative, executive or administrative branch of government exercise general control over the entity in question?

   2. Does the entity perform a traditional government function or a function which in more modern times is recognized as the responsibility of the state?

   3. Is the entity one that acts pursuant to statutory authority specifically granted to it to enable it to further an objective that government seeks to promote in the broader public interest?

   McKinney, supra at p. 592

6. An affirmative answer to any or all of these three questions would, according to Wilson J., provide a strong indication that the entity in question forms a part of "government." None of these questions would be determinative since it would always be open to the parties in any particular case to explain that there may be some other feature of the entity which makes it part of government but which is not dealt with in the above questions.

7. Using this broader test, Wilson J. found that universities in issue in McKinney fell under Charter scrutiny. She reasoned that the provincial government in that case exercised substantial control both directly and indirectly over universities in the areas of funding, governing structure, decision-making processes and government policy. In addition, Wilson, J. found that control over education has always been a traditional function of governments in Canada and that provincial governments have always had a vital interest in having a first-class educational system. Thus, in her view, the Charter applied.

   McKinney at pp. 597-599

8. The Supreme Court was divided along similar lines in both Harrison and Stoffman which dealt with the mandatory retirement policies of a university and of a hospital, respectively. In each case the majority focused on the difference between ultimate or extraordinary control and routine or regular control. The majority found that the policies of both the hospital and the university were the result of day-to-day decisions made by the institutions which were not subject to governmental authority. Although the incorporating statutes provided for

governmental approval of broad policy decisions, the policies in question were not subject to governmental approval. Therefore the majority found that the Charter had no application.

9. In the Douglas College case the entire Supreme Court decided that the Charter applied to policies of the community college before them. La Forest J., for the majority distinguished between the universities considered in McKinney and the community college in issue in Douglas College. He noted that the government established the community college as a crown agency which would implement government policy and that the government could at all times by law direct the operation of the community college. Therefore all functions of that community college could be considered to be acts of "government".

Douglas College at p. 110

10. The Supreme Court came to a similar finding in Lavigne. In a concurring judgment, Wilson J. once again applied her three part test in McKinney. She noted that the majority reasons in McKinney do not provide a particularly clear test as to the scope of "government". By relying on her three part test from McKinney Wilson, J. agreed with the conclusion of the majority, namely that the Charter applied to a collective agreement between the Ontario Public Service Employees Union and the Board of Regents, which was an emanation of "government".

Lavigne at p. 564

11. There is still considerable doubt as to the components of the test to be applied when determining if an entity is part of "government" for purposes of the Charter. Since the test enunciated by the majority of the Supreme Court in McKinney is so vague, it is possible that the exhaustive three part test enunciated by Wilson J. may be applied in future cases. If the majority judgment in McKinney is applied to the CPSO it can be argued that the CPSO is a governmental emanation. It is arguable that the CPSO would also be "government" under Wilson J.'s test.

12. Alternatively, it is possible to argue that the Discipline Committee is exercising a delegated executive function so that it can be considered to be part of the executive branch of government and therefore subject to Charter scrutiny. Two main propositions emerge from La Forest J.'s consideration of whether the impugned regulation in Stoffman was an act of the executive branch of government. First, the fact that regulations passed by the entity in question are subject to ministerial approval is not a certain indicator that such regulations represent actions of the executive branch. Second, actions falling within the executive branch of government are ones which represent "delegated legislation" as opposed to "rules or directives of internal management".

Stoffman, supra at pp. 736-737

13. La Forest J. found that the mandatory retirement policy in Stoffman was not delegated legislation but instead was "quintessentially a rule or directive of internal management" (Stoffman at p. 263). His reasons were based on the fact that there was no evidence that the regulation was instigated by the Minister or that it in any way represented ministerial policy.

Stoffman, supra, at p. 737

14. Section 50 of the H.D.A. provides that the Council may make regulations "subject to the approval of the Lieutenant Governor-in-Council and with prior review by the Minister". These include governing standards of practice for the profession defining professional misconduct; and respecting any matter ancillary to the issuing, suspension and revocation of licences. In contrast, s. 51 provides that the Council may pass by-laws "relating to the administrative and domestic affairs of the college" without a corresponding requirement of approval and consultation. By-laws provided for by s. 51 include matters such as banking and finance, prescribing the seal, and fixing the financial year.

Health Disciplines Act, ss. 50(d), 50(g), 50(m), 51.

15. Using the reasoning in Stoffman it is arguable that s. 50 of the H.D.A. provides for delegated legislation (i.e. policy implementation) while s. 51 provides for internal management. Therefore it could be argued that the Council, in enacting regulations pursuant to s. 50 of the H.D.A., is "effecting a ministerial design". In so doing the Council would be carrying on a government function which would attract Charter scrutiny.

16. Even if the CPSO cannot be considered to be "government" for the purposes of s. 32(1) of the Charter, if the council of the College is implementing "governmental action" then the CPSO would still be subject to Charter scrutiny. Regulations under statute are "governmental action" and may be challenged under the Charter. The disciplinary rules of the CPSO are embodied in regulations enacted by the Council of the College and passed with ministerial approval pursuant to s. 50 of the H.D.A. There is a good probability that the disciplinary rules will themselves be considered to be "governmental action". If so, the Charter will apply to those rules.

17. In Re Klein and the Law Society of Upper Canada the majority of the Ontario Divisional Court found that the Charter was applicable to the Discipline Committee of the Law Society. The court held that the Law Society is an authority exercising its jurisdiction in the public interest and so it is performing a regulatory function "on behalf of" the Legislature and Government of Ontario. This finding in Klein is still good law in Ontario given that it has not been directly overturned. It was cited by the Supreme Court majority in both McKinney and Stoffman, although it was neither expressly approved nor disapproved. Insofar as Klein is good law it appears likely that if the Charter applies to the Law Society of Upper Canada it also applies to discipline committees of other self-regulating bodies such as the CPSO.

Re Klein and the Law Society of Upper Canada (1985), 50 O.R. (2d) 118 (Ont. Div. Ct.)

18. The Supreme Court of Canada has ruled that regulations restricting dental advertising under the H.D.A. are in contravention of the Charter. It should be noted however that the regulations in that case were made pursuant to the statute itself and not pursuant to a board created under that statute. Therefore it is not clear that the application of the Charter in that case can be extended to regulations which may be passed by the council of the college rather than by the Ontario Legislature.

Rocket v. Royal College of Dental Surgeons, [1990] 2 S.C.R. 232.

19. In the final analysis, the question of the applicability of the Charter to the CPSO is by no means certain. However, the bulk of caselaw to date suggests that the Charter will eventually be applied to the CPSO. This is not to say that the Charter will be successfully invoked to strike down the Task Force Recommendations. As can be seen from the chapters which follow, a number of legal arguments exist in support of the view that many of the Recommendations do not infringe constitutionally protected rights and other legal arguments support the view that any rights violations are nevertheless justified under s. 1 of the Charter.

CHAPTER 3 - DOES SECTION 7 OF THE CHARTER APPLY TO CPSO PROCEEDINGS?

1. Section 7 of the Charter provides as follows:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The "principles of fundamental justice" are an important source of procedural protection to individuals. Since many of the Recommendations affect disciplinary procedures, the question of when individuals may invoke the procedural protections embodied in the principles of fundamental justice is key. This is considered in this chapter. Precise protections given by the principles of fundamental justice are considered in some of the chapters which follow and especially in chapter 10.

2. Consideration of "fundamental justice" under s. 7 of the Charter is only necessary if an infringement of "life, liberty and security of the person" under s. 7 is found. It is submitted that although the point is still quite open in that the Supreme Court of Canada has not definitively resolved the matter, the trend in the case law is against recognizing that a "right to work" or a "right to practice one's profession" is protected within "life, liberty and security of the person".

3. Although there is authority to suggest that "reputation" or "dignity" interests receive some protection under "life, liberty and security of the person", the situations when a claimant may successfully advance such a claim are likely to be somewhat rare.

4. Accordingly, we envisage few circumstances involving disciplinary matters in which a claimant can successfully assert that his or her "rights to life, liberty and security of the person" are infringed. In light of this, it is unlikely that the "principles of fundamental justice" will frequently apply to disciplinary proceedings.

THE RIGHT TO PRACTICE ONE'S PROFESSION

5. The bulk of authority suggests that s. 7 protection does not extend to "pure" economic interests (i.e. property). The key Supreme Court judgment is Irwin Toy:

> The intentional exclusion of property from s. 7 ... leads to a general inference that economic rights as generally encompassed by the term "property" are not within the perimeters of the s. 7 guarantee. This is not to declare, however, that no right with an economic component can fall within "security of the person"... we do not at this moment, choose to pronounce upon whether those economic rights fundamental to human life or survival are to be treated as though they are of the same ilk as corporate-commercial economic rights.

Irwin Toy Limited v. A.G. Quebec, [1989] 1 S.C.R. 927 at 1003-1004

6. Case law on the issue (variously described as the "right to work", the "right to earn a livelihood", "the right to pursue a profession" or "the right to continue in a profession") is badly split; the Supreme Court itself has avoided pronouncing definitively on the issue, although a few Justices have expressed personal opinions. Thus, La Forest J. has, speaking only for himself, stated that

> It is still an open question whether the right to earn a livelihood is a value constitutionally protected under the Charter, perhaps under s. 7. But whether or not such constitutional protection exists, no one would dispute that the "right" to earn a livelihood is an interest of fundamental importance to the individuals affected, and as such should not lightly be overridden,
>
> Andrews v. Law Society of British Columbia (1989), 36 C.R.R. 196 at 213 (S.C.C.)

and Lamer C.J.C. has stated that:

> ... the rights under section 7 do not extend to the right [of prostitutes] to exercise their chosen profession.
>
> Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (the "Prostitution Reference") (1990), 109 N.R. 81 (S.C.C.) at 143

7. Ontario courts have consistently held that there is no "right to work". The Ontario Court of Appeal, for instance, has stated that "there is no constitutional right to practice medicine".

Re Jamorski (1988), 64 O.R.(2d) 161 at 168

8. There may be a distinction between the right to enter a particular calling and the right to continue in the calling once one has entered into it. Lower court decisions outside of Ontario have emphasized the distinction between entering and continuing in a profession. Some support for this distinction may come from the recognition by the Supreme Court that in certain instances the occurrence of stigmatization may evoke the protection of s. 7. In another case, the Ontario Court of Appeal assumed without deciding that the protection of reputation is within the scope of s. 7.

Howard v. Architectural Institute (B.C.) (1989), 39 B.C.L.R. 277 (B.C.S.C.)
Re Branigan and Yukon Medical Council (1986), 26 D.L.R. (4th) 268 (Y.T.S.C.)
R. v. Vaillancourt, [1987] 2 S.C.R. 636

Richman v. Wheaton (1989), 36 O.A.C. 192 (Ont. C.A.)

9. The British Columbia Court of Appeal has expressed the strongest views in favour of some form of "professional" protection, stating that:

> "Liberty" within the meaning of Section 7 is not confined to mere freedom from bodily restraint... it may embrace individual freedom of movement, including the right to choose one's occupation and where to pursue it, subject to the right of the State to impose, in accordance with the principles of fundamental justice, legitimate and reasonable restrictions on the activities of individuals.
>
> Wilson v. B.C. Medical Services Commission (1988), 53 D.L.R. (4th) 171 (B.C.C.A.) at 186-87

The court relied heavily for this conclusion on a statement in a dissenting judgment by Dickson C.J.C. - It is as follows:

> It has been suggested that associational activity for the pursuit of economic ends should not be accorded constitutional protection. If by this it is meant that something as fundamental as a person's livelihood or dignity in the workplace is beyond the scope of constitutional protection, I cannot agree ... a person's employment is an essential component of his/her sense of identity, self-worth and emotional well being. Accordingly the conditions in which a person works are highly significant in shaping the whole compendium of psychological, emotional and physical elements of a person's dignity and self-respect.
>
> Reference re Public Service Employee Relations Act, [1987] 3 W.W.R. 577 at 618 (S.C.C.)

10. While leave to appeal Wilson to the Supreme Court was refused, the authoritative weight of the case has been dealt a significant blow by Lamer C.J.C. in the Prostitution Reference in which, speaking for himself, he stated at pp. 131-32:

> It seems to me that the distinction sought to be drawn [in Wilson] between a right to work and right to pursue a profession is, with respect, not one that aids in an understanding of the scope of "liberty" under section 7 of the Charter ... if liberty or security of the person under section 7 of the Charter were defined in terms of attributes such as dignity, self-worth and emotional well-being, it seems that liberty under section 7 would be all inclusive. In such a state of affairs there would be serious reason to question the independent existence in the Charter of other rights and freedoms such as freedom of religion and conscience or freedom of expression.

The one door left open by Lamer C.J.C. in the case was the somewhat cryptic statement at p.141:

> Section 7 is implicated when the state, either directly or through its agents, restricts certain privileges or liberties by using the threat of punishment in cases of non-compliance. (emphasis added)

11. The difficulty faced by those who would advocate that the permanent revocation of a licence to practice medicine infringes liberty and security of the person is the fact that recent statement by certain Justices in the Supreme Court of Canada (e.g. Lamer J. in the Prostitution Reference) suggest that the Supreme Court is likely to define s. 7 very narrowly. Further, the Ontario Court of Appeal has not followed the liberal line of cases such as Wilson from the British Columbia Court of Appeal. In cases such as R. v. Quesnel, R. v. Miles of Music Ltd., R. v. Videoflicks and Biscotti v. Ontario Securities Commission, the Ontario Court of Appeal has rejected the arguments that s. 7 protects a "right to work" or a "right to practice one's livelihood". In light of these cases, it is unlikely that persons appearing before Ontario disciplinary tribunals will be able to maintain successfully that their rights to life, liberty and security of the person are being infringed.

CHAPTER 4 - DO CRIMINAL RIGHTS IN THE CHARTER APPLY TO CPSO PROCEEDINGS?

1. Section 11 provides that any "person charged with an offence" [emphasis added] has certain rights. These rights are indicated by the margin note to the section to apply to "proceedings in criminal and penal matters." Since the decision of the Supreme Court in R. v. Wigglesworth, [1987] 2 S.C.R. 541; 81 N.R. 161, it is commonly assumed that s. 11 of the Charter does not apply to disciplinary proceedings. The bulk of authority supports this proposition.

> R. v. Wigglesworth, [1987] 2 S.C.R. 541; 81 N.R. 161
> Pearlman v. Manitoba Law Society Judicial Committee (unreported decision of the S.C.C., released September 26, 1991)

2. In Wigglesworth, Wilson J. identified two branches of s. 11: the first branch applies to proceedings "by nature criminal"; the second to proceedings not by nature criminal but in which a conviction in respect of the offence may lead to a "true penal consequence".

> R. v. Wigglesworth, supra.

3. A proceeding "by its nature criminal" was identified as being one concerned with

> "matter[s] of a public nature, intended to promote public order and welfare within a public sphere of activity",

which were distinguished from

> "private domestic or disciplinary matters which are regulatory, protective or corrective and which are primarily intended to maintain discipline, professional integrity and professional standard or to regulate conduct within a limited private sphere of activity".

A proceeding by its nature criminal need not entail serious consequences following conviction in order to qualify for inclusion under s.11: a parking infraction, for instance, qualifies.

4. "Penal consequence" in turn has two separate branches, which are respectively

   (a) imprisonment; and

   (b) a "fine which by its magnitude would appear to be imposed for the purpose of redressing the wrong done to society at large rather than to maintenance of internal discipline within the limited sphere of activity" (emphasis added).

5. While Wilson J. continued by stating that it was hard to conceive of a proceeding failing the "nature" test but passing the "penal consequence" test, the proceedings in Wigglesworth in fact did precisely this: although the court held that proceedings under the R.C.M.P Act were not by nature criminal, the accused police officer was nevertheless found to have been charged with an "offence" under the Act, which provided for a true penal consequence - a maximum penalty of one year's imprisonment.

6. It is clear by analogy to Wigglesworth that C.P.S.O. Discipline Committee proceedings are not by nature criminal. If the Task Force's finding that the Discipline Committee typically requires a criminal standard of proof almost beyond a reasonable doubt is correct, Wigglesworth supports the assertion that the Committee is applying a standard which is not required by s. 11 of the Charter.

7. Disqualification from practice itself is not a "penal consequence", despite the severe economic consequences it entails.

> Trumbley and Pugh v. Toronto Police, [1987] 2 S.C.R. 577
> Burnham v.Ackroyd, [1987] 2 S.C.R. 572
> Trimm v. Durham, [1987] 2 S.C.R. 582
> Wigglesworth, supra at 183 (N.R.)

8. Section 60(5) of the Health Disciplines Act provides for a maximum fine imposed by the Discipline Committee of the College of ten thousand dollars to be paid to the Consolidated Revenue Fund. Despite the fine's destination which is where criminal fines normally go, it is unlikely that the maximum levy is of sufficient magnitude to attract s. 11 applicability. The consistently restrictive judicial attitude towards s. 11 evidenced in lower court cases reinforces this conclusion.

> Re Kodellas and Saskatchewan Human Rights Commission (1986), 34 D.L.R. (4th) 30, (Sask. Q.B.), appeal allowed in part on other grounds (1989), 60 D.L.R. (4th) 143 (Sask. C.A.).
> R. v. Shubley, [1990] 1 S.C.R. 3

9. It is clear that Discipline Committee proceedings, like those under the R.C.M.P. Act, are not by nature criminal, but concerned with the maintenance of discipline and integrity within the profession. It is also clear that the penalty of disqualification from practice will not per se attract s. 11 applicability. The critical issue in the case of C.P.S.O. Discipline Committee proceedings is rather whether a possible twenty thousand dollar fine payable to the Consolidated Revenue Fund is in of sufficient magnitude to constitute a "penal consequence" which will attract the application of s. 11. The inference from the case law is that it is not, and that consequently s. 11 does not apply to proceedings before the Discipline Committee.

CHAPTER 5 - GUIDELINES ON DOCTOR-PATIENT RELATIONS

Recommendations discussed herein: 10, 11, 12

1. Although Recommendations 10 and 11 are currently phrased only as guidelines, they may yet be entrenched as Regulations following the deliberations of the Guidelines Committee referred to in Recommendation 12. As rules, they may be subject to challenge on freedom of association grounds. The Recommendations arguably prevent persons from associating because of the limitations they impose on doctors pursuing relationships with patients.

2. Recent Supreme Court of Canada decisions reveal the following propositions concerning the meaning and scope of s. 2(d):

   (a) s. 2(d) protects the freedom to establish, belong to and maintain an association;
   (b) s. 2(d) does not protect an activity solely on the ground that the activity is a foundational or essential purpose of an association;
   (c) s. 2(d) protects the exercise in association of the constitutional rights and freedoms of individuals; and
   (d) s. 2(d) protects the exercise in association of the lawful rights of individuals.

   Professional Institute of the Public Service of Canada v. Northwest Territories (Commissioner), [1990] 2 S.C.R. 367 ("PIPSC"), per Sopinka J. summarizing previous Supreme Court decisions

3. The trend in the reported decisions has been to interpret s. 2(d) narrowly. Thus the right may not protect "intimate" association. If this is the case, freedom of association may not be infringed when restrictions are placed on activities engaged in by doctors and patients.

   R. v. Skinner, [1990] 1 S.C.R. 1235;
   R. v. Stagnitta, [1990] 1 S.C.R. 1226;
   Reference re Public Service Employee Relations Act (Alta.), [1987] 1 S.C.R. 313, per McIntyre, J. (espousing a narrow view of s. 2(d)); and per Dickson, C.J.C. (dissenting) (espousing a "broad" view).

4. The issue of "intimate association" has not directly been litigated in higher level courts in Canada. However, in the related "family" context, lower courts have given a narrow interpretation to s. 2(d), and challenges have typically been unsuccessful. Findings include the following:

   a. s. 2(d) does not include the freedom to marry;

      R. Gray et al. and Minister of Manpower and Immigration (unreported, May 6, 1985) (F.C.T.D., Denault J.).

b. s. 2(d) does not extend to the filial association of parent and child;

Re Downes and Minister of Employment and Immigration (1986), 1 A.C.W.S. (3d) 28 (F.C.T.D.);
Nova Scotia (Minister of Community Services) v. S.(M.K.) (1988), 86 N.S.R. (2d) 209 (Co. Ct.), affd 88 N.S.R. (2d) 418; 19 R.F.L. (3d) 75 (C.A.);
C.C.A.S. (Metro Toronto) v. S.(T.) (1989), 60 D.L.R. (4th) 397, 69 O.R. (2d) 189, 20 R.F.L. (3d) 337 (C.A.)

and

c. s. 2(d) does not include the freedom of a husband and wife to cohabit in Canada.

Re Horbas and Minster of Employment and Immigration (1985), 22 D.L.R. (4th) 600 (F.C.T.D.).

5. The debate over the dating limitations in Recommendations 10 and 11 revolve around whether there should be a specified (hence necessarily somewhat arbitrary) time limit, or whether the ban should be based on qualitative considerations such as the persistence in the relationship of power inequality and undue influence. Given the narrow judicial approach to s. 2(d) taken to date, and the trend towards judicial deference with respect to legislative "line drawing" in s. 1 (the section dealing with justification of rights violations), particularly in cases involving vulnerable groups (see chapter 11 regarding justification), there are good reasons to believe that even a quantitative limit such as two years is unlikely to be defeated.

C.C.A.S. (Metro Toronto) v. S.(T) (1989), 60 D.L.R. (4th) 397 (Ont. C.A.)
Re S. and Minister of Social Services (1983), 21 A.C.W.S. (2d) 218 (Sask. Q.B.)

CHAPTER 6 - THE CPSO REPORTING SYSTEM

Recommendations discussed herein: 15 - 23, 35

1. Recommendations 15 to 23 outline a system designed to improve the reporting of sexual abuse of patients. These Recommendations address what is perceived to be one of the drawbacks of the present system - that the Complaints Committee is prohibited from acting without a written complaint, while victims frequently are unwilling or unable to risk the consequences of identification as a formal "complainant".

2. At present, an allegation of physician abuse may give rise to one of two forms of investigation: (a) a "routine" investigation, the result of which, if accompanied by a written complaint, will be forwarded to the Complaints Committee; or (b) an investigation under s. 64 of the Health Disciplines Act (HDA),

3. Current CPSO routine practice includes the following:

   (a) upon receipt of a written complaint, an "investigator" will interview the complainant and sometimes the doctor, and examine documents in the complainant's possession, and may interview other witnesses to whom the investigator is referred by the complainant. This procedure may occur before the Complaints Committee hears of the complaint, which may be presented to the Committee at the same time as the investigator's report;

   (b) sometimes an investigator will interview the complainant even without a written complaint, and may assist the complainant in drafting the complaint. This practice appears consistent with the statute: while the Committee may not dispose of a matter without a written complaint, it is not prevented from investigating without one - see HDA s. 58(1).

4. Investigators appointed by the Registrar under s. 64 have the following powers:

   (i) the power to issue summonses and order production of documents - Public Inquiries Act, R.S.O. 1980 c.411 s. 7(1); HDA s. 64(2);

   (ii) the power to enter and inspect the physician's business premises without notice to examine documents relevant to the investigation - HDA s. 64(2);

c (iii) the power to remove and copy relevant documents found on those premises - HDA s. 64(5); and

   (iv) the power to make an ex parte application for a warrant to search any other premises for relevant documents, if a justice of the peace is persuaded that

there are reasonable grounds for believing these may be found in such a location, including the power to enter by force if necessary - HDA s. 64(4).

5. A s. 64 investigation "may" be initiated by the Registrar if

(a) he/she believes on reasonable grounds that a physician has committed an act of professional misconduct or incompetence, and

(b) the Executive Committee approves commencing the formal investigation.

6. At present, allegations of physician abuse, unless submitted in written form by the complainant, are not "stored" by the CPSO, although a telephone caller, for instance, may receive a form of "help-line" counselling.

Recommendation 15, 16, 17 would add the following elements to the current reporting system:

(a) recording and retaining non-written allegations of physician abuse, whether the reporter is identified or anonymous;

(b) mandatory reporting by members of the College, identifying the reporting member and the member being reported;

(c) establishing a mechanism whereby the Registrar and Executive Committee will be informed if the College has received two reports, in whatever form, of patient sexual abuse.

7. The Task Force Recommendations thus provide a mechanism whereby a "s. 64 investigation" and subsequent disciplinary proceedings may be initiated in the absence of a written complaint. HDA s. 64 in fact already allows for this scenario, except that it is unclear in the HDA how the Registrar would hear of sexual abuse allegations except through the Complaints Committee.

8. The basic components of any reporting system are:

(a) the "gate": what information is accepted into and stored by the system. In the present system, the types of information are:

(i) the alleged victim's name (and location, etc.);
(ii) the alleged abuser's name;
(iii) the reporter's name.

In addition, the circumstances of the incident reported could form part of the report.

(b) notice: who, if anyone is informed of the report, and, if they are informed, whether they are informed of the entire report. Persons who might be notified by the system include:

(i) the alleged victim (for instance if the victim is not herself the reporter);
(ii) the alleged abuser;
(iii) others (for instance, if the alleged victim is a child, his/her parents, guardians, etc.)

(c) the use made of the report. The issues here include

(i) initiating investigation; and
(ii) admissibility as evidence.

9. In the proposed reporting system:

(a) reports need not (indeed, may be required not to) include the alleged victim's name;

(b) reports need not include the reporter's name - that is, they could be anonymous;

(c) the system does not provide for an "active" notice mechanism, and may not provide for a "reactive" response to an alleged abuser's enquiry;

(d) after the second report, the Registrar is notified, and thereafter the Registrar and Executive Committee have the discretion to initiate the investigatory process under HDA s. 64, if they conclude that the reports furnish "reasonable and probable grounds" for belief that "professional misconduct or incompetence" has occurred.

(1) PRINCIPLES OF FUNDAMENTAL JUSTICE

10. Implementing the Recommendations will create a "list" of suspected abusers similar to the child abuse registers in place in many provinces. The list would be "secret" in that the physician whose name was entered in it would neither be alerted to its existence nor have access to its contents as they pertain to the physician.

11. Before discussing whether these Recommendations are vulnerable to a challenge based upon the "principles of fundamental justice" under s.7, it must first be emphasized that these principles apply only if rights to life, liberty and security of the person are infringed. For the reasons expressed in chapter 3, there are sound arguments in favour of the view that rights to life, liberty and security of the person are not infringed in many cases and so the principles of fundamental justice do not apply. The discussion which follows assumes that the principles of fundamental justice apply.

12. In challenges to provincial child abuse register systems, such secret lists have been held to infringe "fundamental justice" in s. 7 of the Charter when inclusion in the list has "negative implications" for those included. The central issue regarding the proposed CPSO system is whether inclusion would have such implications.

> St. Hilaire v. Director of Child and Family Services (1987), 30 C.R.R. 10 (Man. Q.B. Fam. Div);
> S. (R.A.) v. Nova Scotia (Ministry of Social Services) (1987), 33 C.R.R. 17, (N.S. Fam. Ct.)

13. First, inclusion may in practice increase the likelihood that a physician will be subject to "routine" investigation. Unlike "s. 64 investigations", there is no threshold to routine investigations. Nothing now prevents such an investigation following a single anonymous complaint, although this is an unlikely occurrence.

14. Second, inclusion may expose the person named to the extensive investigatory procedure of HDA s. 64, which may have significant negative consequences for one's business and personal reputation, even before disciplinary proceedings commence. Nevertheless, this may not be a "negative implication" which would give rise to a breach of the principles of fundamental justice because:

    (a) the s. 64 process may not be initiated without reasonable and probable grounds; and

    (b) the "right to continue practising one's profession", even when considered from the non-economic perspective of implications for dignity and reputation, is not protected by the rights to life, liberty and security of the person under s. 7.

15. Finally, inclusion in the list exposes the included physician to the prospect of disciplinary proceedings, but only in the event the investigation so warrants.

16. The impact on individuals' s. 7 rights, if any, can be minimized by reducing the injurious effects of "negative implication" arising from inclusion in the list. This may be done by:

    (a) ensuring that the list cannot be leaked;

    (b) ensuring the confidentiality of "routine" investigations, and possibly developing some minimal threshold even for these investigations; and

    (c) emphasizing that the Registrar in fact has no authority to order an investigation under s. 64 unless there are "reasonable and probable grounds [for believing] that a member has committed an act of professional misconduct".

17. Since reasonable and probable grounds may well require something more than two anonymous phone calls, it would appear consistent with the spirit and purpose of the Act to develop a policy to assist in deciding when the investigatory threshold is met. If no investigation is taken without reasonable and probable grounds for such a belief, then even if an investigation is undertaken which impinges on the physician's liberty or security of the person, it is more likely to be found to be in accordance with the principles of fundamental justice or, in any event, to be saved through the application of s. 1 of the Charter.

18. Any reports made to the CPSO are required by HDA s. 65 to be kept confidential, a significant exception being "except with the consent of the person to whom the information relates" - s. 65(1)(d). Strictly interpreted, this section would preclude even communication between phone-answering personnel at the CPSO to determine if more than one complaint had been made against a particular physician. At the least, then, the system envisaged by the Task Force will require a new regulation or by-law - s. 65(1)(a).

19. Recommendation 35 acknowledges the confidentiality issue, but may not go far enough to satisfy s. 65, which would appear to preclude, without at least an amendment to the regulations, the "Minnesota model", whereby the physician's other patients are contacted at a certain stage in the proceedings.

(2) FORCED SPEECH

20. The mandatory reporting envisaged by the Task Force recommendations may violate s. 2(b) of the Charter. It is clear that freedom of expression includes the freedom not to be forced to express oneself:

> "Silence is in itself a form of expression which in some circumstances can express something more clearly than words can do".
>
> Slaight Communications Inc. v. Davidson, [1989] 1 S.C.R. 1038, 59 D.L.R. (4th) 416. (per Lamer J. (as he then was) (dissenting), at p. 446 D.L.R.).

21. In Slaight, a labour arbitrator's order that the employer provide his former employee with a letter of recommendation specifying certain facts, was held by the majority to be a clear violation of s. 2(b), but was saved under s. 1.

22. If the objective of remedying one person's unjust dismissal was held to be pressing and substantial enough to satisfy the s. 1 Oakes test in Slaight, it is likely the objective of bringing sexually abusive doctors to justice would also meet that test.

23. In the absence of direct case law on forced speech in the context of mandatory reporting, the reasoning in Slaight should apply, and should lead to the Recommendations being upheld under s. 1. Further discussion regarding s. 1 is found in chapter 11.

(3) FREEDOM OF INFORMATION

24. It seems clear that the Freedom of Information and Protection of Privacy Act, S.O. 1987, c. 25 as amended (the "FOIA") does not apply to the College of Physicians and Surgeons of Ontario.

25. Under FOIA s. 1(1), "every person has a right of access to a record...under the control of an institution", unless the matter falls within one of the exemptions in s. 12. Under FOIA s. 2(1), an "institution" means an agency defined as such in the regulations (O. Reg. 516/90).

26. Under s. 2(1) of the regulations, "institutions" are defined as those included in the Schedule. The Schedule lists 239 institutions, including the Health Disciplines Board, but no Colleges under the HDA.

27. Since the HDA creates the Board and the Colleges as separate entities, it is unlikely that the inclusion of Colleges in the Schedule is subsumed under the inclusion of the Board. It is therefore reasonable to assume that the legislature intended the exclusion of the CPSO from the application of the FOIA.

28. If this conclusion is incorrect, it is possible that the CPSO could nevertheless restrict access to information concerning sexual abuse of patients under the exemption in s. 20 - where disclosure would "be expected to seriously threaten the safety or health of an individual".

FOIA, s. 20.

CHAPTER 7 - SEARCH AND SEIZURE ISSUES

1. In recommending that the College "exercise its jurisdiction" to seize documents "at the beginning of the investigation process", the Task Force is not necessarily recommending a change to the present procedure. A challenge to the constitutionality of CPSO investigatory mechanisms consequently involves consideration of the Act as it presently exists, rather than a specific Task Force recommendation.

2. Section 8 of the Charter provides that "everyone has the right to be secure against unreasonable search or seizure". What constitutes an "unreasonable" search or seizure depends on the "reasonable expectation of privacy" of the subject of the search or seizure.

   Hunter v. Southam, [1984] 2 S.C.R. 145 at 157-159

3. Critical in determining a doctor's reasonable expectation of privacy are the provisions in Regulation 448, R.R.O., 1980 as amended. Section 29 of the Regulation requires a physician to keep records which include particulars of each physical examination of a patient - s. 29(1)(a)(iv), and to make all such records available at reasonable hours for inspection by an investigator appointed by the Registrar under s. 64 of the HDA - s. 29(3).

   Regulations (Medicine) R.R.O. 1980, as amended, s.29

4. The Ontario regulation has not been challenged. In a challenge to a similar regulation, however, the British Columbia Supreme Court held that while a demand by an investigator to inspect and copy the records for twenty patients, without taking them away, amounted to a seizure (because it was a "forced production of documents"), it was not unreasonable under s. 8 of the Charter, particularly in light of the College's regulatory task.

   College of Physicians and Surgeons (B.C.) v. Bishop (1989), 34 B.C.L.R. (2d) 175 (B.C.S.C.).
   R. v. McKinlay Transport Ltd., [1990] 1 S.C.R. 627

5. In an earlier case, Bishop v. College of Physicians and Surgeons (B.C.) (1985), 22 D.L.R. (4th) 185 (B.C.S.C.), affirmed [1986] 3 W.W.R. 377 (B.C.C.A.), the British Columbia Court of Appeal held that a provision similar to the one existing in the HDA allowing an investigator to remove files from the doctor's office constituted an unreasonable seizure because of its impact on the doctor's practice and because of the confidentiality of some of the information involved. The province subsequently amended the regulation to permit records to be inspected and copied but to be taken away only with the doctor's permission. A practice of on-site copying is consequently advised for the CPSO.

6. The courts have identified the following factors in determining the reasonableness of administrative seizures:

(a) the purpose of the statutory scheme;

(b) the nature of the thing seized;

(c) the character of the premises;

(d) the expectations of the party involved; and

(e) the urgency of the situation.

Thomson Newspapers Ltd. v. Director of Research and Investigation (1990), 67 D.L.R. (4th) 161 (S.C.C.)
R. v. Dyment, [1988] 2 S.C.R. 417
R. v. Bertram S. Miller Ltd., [1986] 3 F.C. 291 (Fed C.A.)

7. In light of the factors quoted above, and the fact that an investigation under s. 64 cannot proceed without reasonable and probable grounds for belief that misconduct has occurred, it appears likely to us that the investigatory process under the present statutory scheme does not constitute an unreasonable search and seizure for the purposes of s. 8 of the Charter.

CHAPTER 8 - MUTUAL DISCLOSURE

Recommendations discussed herein: 43, 49

1. Recommendations 43 and 49 in no way impinge upon the accused's present statutory right to full disclosure of the prosecution's case. Under the new RHPA, the accused's right to disclosure will be even broader than the present provisions.

2. The aim of the Recommendations is to attempt to make the disclosure process a more balanced "two-way street". Currently, the prosecution is obliged to provide detailed information of its case, including "will says", while the accused doctor need not provide information as to the defence to be presented. The doctor may write a letter in response to the initial complaint, but these letters often contain no details of the defence beyond a mere denial of the allegations. The defence need not even inform the prosecution who their witnesses will be (including expert witnesses), often resulting in surprises and difficulties in cross-examination.

   HDA, s. 12(2)
   RHPA, s. 41, Procedural Code

3. There is no common law right of an administrative tribunal to production and discovery from a person appearing before it. However, in Canada, there are many statutory provisions relating to criminal, civil and regulatory actions, authorizing various levels of pre-hearing disclosure.

   Rules of Civil Procedure, O. Reg. 560/84, as am, Rules 30-36; 50;
   Criminal Code, s. 625.1;
   Ontario Energy Board, (written interrogatories)
   Ontario Human Rights Commission; Ontario Pay Equity Commission, (pre-hearing conferences).

4. The Law Reform Commission of Canada has concluded that full discovery is essential for the rational functioning of an adversarial model, no matter how the proceedings were characterized, (i.e., civil or criminal).

   Law Reform Commission of Canada, Study Report, Discovery in Criminal Cases, 1974, at p. 41.

(1) THE PRINCIPLES OF FUNDAMENTAL JUSTICE

5. The Supreme Court has recently held that the principles of fundamental justice enshrined in s. 7 include the right to remain silent.

Thomson Newspapers Ltd. v. Director of Investigation and Research et al, [1990] 1 S.C.R. 425, 67 D.L.R. (4th) 161
R v. Chambers (1990), 59 C.C.C. (3d) 321 (S.C.C.)
R v. Hebert, [1990] 2 S.C.R. 151

6. Assuming that pre-trial disclosure can be characterized as compelling testimony, s. 7 will probably not be violated by a mutual disclosure system. It is clear from recent Supreme Court cases that the principles of fundamental justice in s. 7 include substantive elements which reflect and expand upon the other Charter and common law rights (Thomson Newspapers; R v. Hebert). Two such rights are s. 11(c) (non-compellability) and s. 13 (right against self-incrimination). It should be noted that the principles of fundamental justice and thus rights to silence in s. 7 do not apply unless rights to "life, liberty and security of the person" are infringed. (See the discussion of this in chapter 3.) For the reasons expressed in chapter 3, in most instances the rights to "life, liberty and security of the person" of persons subject to a mutual disclosure system will not be in jeopardy, so the rights of silence in s. 7 will not apply.

7. In determining whether the order to testify in Thomson Newspapers violated the principles of fundamental justice, the Supreme Court looked at several factors including: whether the person testifying was given use immunity in subsequent proceedings (including derivative evidence); the nature of the proceedings (inquisitional vs adversarial); the public interest in the process the disclosure is designed to achieve; the opportunity given to challenge or appeal an order to testify; and the historical backdrop of our legal tradition. Similar factors will probably be utilized to measure the Task Force Recommendations against the principles of fundamental justice, assuming that those principles apply. However, the Thomson Newspaper case dealt with testimony under oath in the investigatory stage of a potential criminal action, with no guarantee of use immunity in relation to derivative evidence. The context of the Task Force Recommendation is quite different, i.e. informal disclosure (until a formal disclosure process can be set up through a statutory amendment) of a legal case, in a non-criminal disciplinary proceeding.

8. The purpose of the Recommendation for mutual disclosure is not to conscript an accused against himself. The prosecution's case will already be assembled by the time of pre-trial disclosure. If orders under the Combines Investigation Act do not infringe s. 7, it is unlikely that mutual disclosure preliminary to disciplinary hearings will violate s. 7. As evidenced by the inability of the Court to reach a majority decision in Thomson Newspapers case, this area of law is far from settled.

(2) FORCED SPEECH

9. Section 2(b) of the Charter may be violated in that the requirements for defence disclosure to the prosecution may constitute forced speech. Applying the caselaw to the proposed disclosure system, it appears that such forced disclosure might violate s. 2(b), but a number

of arguments support the justification of any rights violations under s. 1 of the Charter. (See chapter 11 for a detailed discussion of the issue of justification of rights infringements.)

Slaight Communications Inc. v. Davidson, [1987] 1 S.C.R. 1038

(3) SEARCH AND SEIZURE

10. Section 8 of the Charter may be violated in that the disclosure of the defence's case may constitute an unreasonable search and seizure. The leading case is, again, Thomson Newspapers. There were five separate judgments in Thomson Newspapers, so a clear ratio is difficult to discern. The court split 3:2 on whether the compelled production of documents constituted an unreasonable seizure.

11. In Thomson Newspapers, four out of the five judgments specifically recognized that the standard for reasonableness under s. 8 varies with the nature of the proceedings and the reasonable expectations of privacy which are present in the case (Sopinka J. did not comment on this issue). In Thomson, the standard for reasonableness was found to be fairly low. The proceedings were of a regulatory nature, and thus had a less strenuous and more flexible standard. The fact that the order affected business, not personal, records relating to activities regulated by the State also produced a low expectation of privacy. As well, L'Heureux-Dubé J. noted that production of such documents was necessary for the achievement of the important socio-economic purpose the Act serves. Applying these factors to the Recommendations dealing with mutual disclosure, it appears that if such disclosure constitutes a seizure, there are arguments supporting the view that it is not an unreasonable seizure.

(4) RIGHT AGAINST SELF-INCRIMINATION

12. Section 13 of the Charter may be violated in that pre-trial disclosure may infringe a testifying witness' right against self-incrimination. However, this section has been held to do no more than enshrine the protection guaranteed by s. 5(2) of the Canada Evidence Act. In order for s. 13 to apply, the pre-trial disclosure must be construed as testimony, and the disclosure process must be construed as proceedings. While the concept of what constitutes "proceedings" has been rather liberally interpreted, it is doubtful that informed, unsworn pre-trial disclosure could constitute "testimony".

Starr v. Houlden, [1990] 1 S.C.R. 366
R. v. Hebert, supra

(5) GENERAL CONSIDERATIONS

13. If the accused's rights are not infringed, it is difficult to see any persuasive reason why disclosure to the prosecution should be denied. As well, a doctor's duty to cooperate with his or her governing body should work to compel fuller disclosure. It has been argued that

the wide investigative powers of the prosecuting body (i.e. the College) means that the prosecution is rarely "surprised". But in cases such as sexual impropriety or violation, the "evidence" often comes down to the physician's word against the complainant's. Expert testimony is often used by the defence as evidence of non-propensity to commit such an offence. All of the College's investigatory powers cannot assist them in preparing the cross-examination of an unknown expert.

> Law Reform Commission of Canada, supra, at p. 87

14. One should not overlook the rights of the complainant. An argument could be made that the current one-way disclosure process infringes the complainant's s. 15 rights to equality under the law. However, unless the complainant is made a party to the proceedings, she or he probably would not have standing to make such a claim. Furthermore, the roles of complainant/accused are not enumerated grounds under s. 15, and it is questionable whether they would constitute analogous grounds.

> Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 618

15. While the criminal/civil comparison should be approached cautiously given the special nature of Disciplinary Committee proceedings, a look at how the two systems (i.e. criminal and civil) operate together is instructive. An accused is compellable to civil discovery even if a criminal action may arise from the same acts. The same considerations should apply here. As MacAulay notes, "The public interest is not served in a trial by ambush."

> Robert MacAulay, Practice and Procedure before Administrative Tribunals (1991) Volume 1, Carswell Publications, paragraph 11.3(m)

16. The Law Society of Upper Canada has recently amended its own Disciplinary Process to allow for a form of defence disclosure to the prosecution, The analogy between lawyers breaching their client's trust and doctors breaching their patient's trust through sexual abuse, is clear. It seems anomalous that other professional bodies would put stronger obligations on their members in this respect.

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CHAPTER 9 - PRIVACY INTERESTS OF DOCTOR AND PATIENT

Recommendation discussed herein: 52

1. Recommendation 52 reflects a strong concern for protecting the identity of sexual abuse victims. The new R.H.P.A. already contains a similar publication ban. The Criminal Code contains a similar section, guaranteeing anonymity upon request to victims of sexual offences. The Criminal Code provisions have withstood Charter challenges based on s. 2(b) (freedom of expression/freedom of the press).

> Canadian Newspapers Co. v. Canada (Attorney-General), [1988] 1 S.C.R. 122
> Regulated Health Professions Act, s. 45, Procedural Code
> Criminal Code, sections 486(3),(4)

2. In Canadian Newspapers, the Supreme Court of Canada held that although the publication ban violated s. 2(b), it was saved by s. 1. The statute protected a social value of "superordinate importance" (i.e., bringing those who commit sexual offenses to justice by encouraging the reporting of sexual assaults, probably the most underreported type of personal crime). The impairment was minimal, considering that the ban was not automatic, and that the media could still attend the trial and report on the conduct of the case.

> A.G. (Nova Scotia) v. McIntyre, [1982] 1 S.C.R. 175
> Canadian Newspapers, supra.

3. When balancing competing public interests under s. 1, (i.e., freedom of expression versus the values of privacy, encouraging complainants to proceed, etc.), the correct approach is a contextual one. The contextual approach;

> ... recognizes that a particular right or freedom may have different value depending upon the context ... the contextual approach attempts to bring into sharp relief the aspect of the right or freedom which is truly at stake in the case as well as the relevant aspects of any values in competition with it.
>
> Edmonton Journal v. Alberta (1989), 64 D.L.R. (4th) 577 (S.C.C.) at p. 584.
> Rocket v. Royal College of Dental Surgeons (1990), 71 D.L.R. (4th) 68
> R. v. Keegstra (1990), 61 C.C.C. (3d) 1 (S.C.C.) at pp. 29-30

4. Although the publication ban in Recommendation 52 may well be found to violate s. 2(b), recent caselaw indicates that the ban will be saved by s. 1, especially considering the court's concern for protecting vulnerable groups. Further discussion of this is found in chapter 11.

Irwin Toy Ltd. v. Quebec (A.G.) (1989), 64 D.L.R. (4th), 577 (S.C.C.)
Canadian Newspapers, supra

5. The accused doctor may claim that the publication ban violates his s. 7 rights under the Charter. However, while s. 7 may protect one's privacy in certain cases (where it is linked to human dignity), the violation must also not be in accordance with the principles of fundamental justice. The principles of fundamental justice include both procedural and substantive elements, and therefore encompass the principle of the open court process.

Edmonton Journal, supra.
R. v. Morgentaler (1988), 44 D.L.R. (4th) 385 (S.C.C.)
R. v. Beare (1988), 55 D.L.R. (4th) 481 (S.C.C.)

6. The importance of the open court process has been recognized in the proposed R.H.P.A., which converts the old "closed" process under the H.D.A. into one in which the presumption of openness applies. Only social values of "superordinate" importance will justify a closed process. Mere protection of an individual's privacy (accused's or complainant's) does not meet this standard.

A.G. (Nova Scotia) v. McIntyre, supra.
Canadian Newspapers, supra.
R. v. D. (G.) (1987), 62 O.R. (2d) 567 (Ont. H.C.)
Regulated Health Professions Act, s. 44, Procedural Code

7. The accused doctor may claim that publication of his or her name, and not the complainant's, may result in an unfair trial. However, s. 11 does not apply to the Discipline Proceedings. Furthermore, s. 7 will probably not be violated merely because future triers of fact at a criminal or civil trial have been exposed to publicity surrounding the College prosecution. The legal system has many built-in safeguards to counteract such dangers. In some cases, publication of the names of the accused may actually help ensure the fairness of the trial for the accused, and for the benefit of society and the administration of justice in general.

R. v. Wigglesworth, supra.
Pilzmaker v. Law Society of Upper Canada (1990), 38 A.L.R. 190 (Ont. H.C.)
R. v. Robertson (1983), 41 O.R. (2d) 764
R. v. Hubbert (1975), 11 O.R. (2d) 464 (Ont. C.A.) Aff'd [1977] 2 S.C.R. 267
Southam Inc. v. R. (1987), 37 C.C.C. (3d) 139 (Ont. H.C.)

8. Finally, the accused doctor may claim that his or her s. 15 rights are violated by granting a publication bar for the complainant, but not the accused. Such a claim appears weak to us. The Supreme Court has held that only those who are suffering discrimination on a ground

listed in s. 15(1) of the Charter (e.g. race, sex, age or mental or physical disability) or a ground analogous to those grounds may assert a s. 15(1) claim. Analogous grounds are those grounds which have been used against vulnerable groups over many years. Doctors would appear to us not to be suffering discrimination on the basis of any such grounds.

R. v. D. (G.) (1987) 62 O.R. (2d) 562 (Ont. H.C.)

CHAPTER 10 - GENERAL PROCEDURAL MATTERS: STANDARD OF PROOF, EVIDENCE, BIAS AND INTERVENORS

(1) STANDARD OF PROOF

1. At page 85 of its Preliminary Report, the Task Force observed that in cases of alleged sexual abuse the Discipline Committee of the College has moved increasingly towards a standard of proof that was described by members of the Discipline Committee as "almost beyond a reasonable doubt". In its Preliminary Report, the Task Force found this evidentiary standard to be inappropriately high for disciplinary hearings before an administrative tribunal.

(i) The Current State of the Law

2. The standard of proof determines the degree of probability that must be established by the evidence to entitle the party having the burden of proof to succeed in proving either its case or an issue in the case. Generally there are two levels of probability. These are commonly referred to as the civil onus and the criminal onus. The civil onus requires the party having it to establish its case, or an issue therein, on a balance of probabilities. The party who has a criminal onus to discharge must prove its case, or an issue therein, beyond a reasonable doubt. Pursuant to s. 12(6) of the Health Disciplines Act, the proceedings before the Discipline Committee of the College of Physicians and Surgeons are to be governed by the rules of evidence in civil proceedings in Ontario.

> Health Disciplines Act, R.S.O. 1980, c. 196, s.12(6).

3. The precise meaning of the civil standard of proof has been the subject of extensive judicial commentary. The leading case on the appropriate standard of proof to be applied by a tribunal in disciplinary proceedings is Re Bernstein and the College of Physicians and Surgeons of Ontario. In this case, the Divisional Court engaged in an extensive review of the jurisprudence dealing with the civil standard of proof. On the basis of this review, O'Leary J. came to the following conclusion at 470:

> The important thing to remember is that in civil cases there is no precise formula as to the standard of proof required to establish a fact. In all cases, before reaching a conclusion of fact, the tribunal must be reasonably satisfied that the fact occurred, and whether the tribunal is so satisfied will depend on the totality of the circumstances including the nature and consequences of the fact or facts to be proved, the seriousness of an allegation made and the gravity of the consequences that will flow from the particular finding.

Similarly, Garrett J. described the standard of proof in this way at 485:

> I hold that the degree of proof required in disciplinary matters of this kind is that the proof must be clear and convincing and based upon cogent evidence which is accepted by the tribunal. I agree with Mr. Justice Schroeder that the burden of proof is to establish the guilt of the doctor charged by a fair and reasonable preponderance of credible testimony, the tribunal of fact being entitled to act upon the balance of probabilities. I think, however, that the seriousness of the charge is to be considered by the tribunal in its approach to the care it must take in deciding a case which might in fact amount to a sentence of professional death against the doctor.
>
> Re Bernstein and the College of Physicians and Surgeons of Ontario (1977), 15 O.R. (2d) 477 (Div. Ct.), at 470 and 485.

4. The approach to the standard of proof enunciated in Bernstein has been followed by the Divisional Court in numerous decisions.

> Re Gilzon and Royal College of Dental Surgeons of Ontario (1979), 22 O.R. (2d) 756 (Div. Ct.).
> Board of Governors v. Brown (1985), 52 O.R. (2d) 591 (Div. Ct.).
> Guthrie v. Ontario Association of Architects (1988), 29 O.A.C. (Ont. Div. Ct.).
> Re Coates and Registrar of Motor Vehicle Dealers and Salesman (1988), 65 O.R. (2d) 526 (Div. Ct.).
> Re Gillen and College of Physicians and Surgeons of Ontario (1989), 68 O.R. (2d) 278 (Div. Ct.) (appeal pending)

5. Recently, the Divisional Court made the following observation in College of Physicians and Surgeons of Ontario v. Boodoosingh, at 479:

> This discipline proceeding is quasi-criminal in nature. The maximum penalty of revocation is more serious than many penalties imposed for criminal offences. A reprimand alone is devastating to the recipient. The person charged with a serious offence under the Health Discipline Act, R.S.O. 1980, c. 196, is entitled to have the case against him proved by cogent evidence.
>
> College of Physicians and Surgeons of Ontario v. Boodoosingh (1990), 73 O.R. (2d) 478 (Div. Ct.) (appeal pending), at 479.

6. The reasoning in Bernstein has also been approved by the Ontario Court of Appeal in Board of Opthamalic Dispensers v. Toth:

> The correct standard is that applicable in civil cases, i.e., proof on a balance of probabilities, with the qualification that before that standard can be said to have been met one must have regard for the proposition

> that the more serious the allegation to be proved, the more cogent must be the evidence.
>
> Board of Opthamalic Dispensers v. Toth, [1990] O.J. No. 1802, File No. 102/88 (C.A.).

7. All of the above-cited jurisprudence indicates that, although the appropriate standard of proof to be applied in disciplinary cases is a civil one, it is more than a mere balance of probabilities. The courts have proposed that a sliding scale of certainty be required to support a finding of misconduct. In short, where the allegations are more serious, the burden of proof must be higher.

(ii) Task Force Preliminary Recommendations and the Bernstein Standard

8. At page 85 of its Preliminary Report, the Task Force on Sexual Abuse observed that, in the aftermath of the Bernstein decision, some members of the Discipline Committee of the College described the standard of proof being applied in sexual abuse cases as "almost beyond a reasonable doubt". The Task Force found this evidentiary standard to be inappropriately high for disciplinary hearings before an administrative tribunal. The implication to be drawn from this finding is that the Discipline Committee's interpretation of the Bernstein standard has hindered the effective enforcement of the College's prohibition against sexual abuse by physicians.

9. A mere clarification of the Bernstein approach is unlikely to yield significant improvements in the enforcement of the College's prohibition against sexual abuse.

10. The Preliminary Recommendation for the adoption of a bare balance of probabilities standard is problematic for several reasons. Firstly, it stands in clear opposition to the concept of fairness that is embodied in a civil standard of proof that varies according to the seriousness of the allegations. The adoption of a bare balance of probabilities standard may also be difficult to support in view of the Task Force Recommendation 24 that some forms of sexual abuse be treated as a new and more serious offence: sexual violation. It is contemplated there that conviction for such an offence would give rise to serious penalties including the mandatory revocation of licence for a minimum of five years and fine. The courts have recognized that such a conviction would involve a stigmatization comparable to that which results from a criminal conviction for sexual abuse and that the penalties handed down by the College are more serious than many penalties imposed for criminal offences (see Bernstein, supra and Boodoosingh, supra). Clearly, a diminution in the standard of proof, when combined with an increase in the severity of offences and penalties, would result in a procedural arrangement which is repugnant to the principles enunciated in Bernstein and subsequent decisions.

11. If the College and the Government so desired, it would be possible to override the common law by legislating that the requisite standard of proof in discipline hearings be a bare balance of probabilities. Such an enactment may, however, be subject to challenge under s. 7 of the Charter of Rights and Freedoms. Section 7 of the Charter guarantees "fundamental justice" to those who suffer a deprivation of their rights to life, liberty and security of the person. At a minimum, the concept of fundamental justice includes the concept of procedural fairness. As noted above, however, on current authority the principles of fundamental justice would rarely be found to apply to disciplinary proceedings of the nature under consideration. (See chapter 3.)

> Singh v. Minister of Employment and Immigration, [1985] 1 S.C.R. 177.

12. Finally, it is important to recognize that even if such an enactment withstood a Charter challenge, it would not guarantee any meaningful change in the way in which the Discipline Committee comes to a decision in particular cases or in the deference exercised by appellate courts on judicial review. The standard of proof is an attempt to articulate in abstract terms a highly ambiguous and complex mental threshold which exists in the mind of a trier of fact. By mandating a shift from the sliding civil standard set out in Bernstein to a bare balance of probabilities standard, the College would attempt to send a signal to the Discipline Committee and the appellate courts. Yet it is unlikely that, in practice, this shift would cause a panel of the Discipline Committee to weigh evidence differently or cause an appellate court to exercise deference where it otherwise would not. If a panel of the Discipline Committee or an appellate court feels that there is insufficient credible evidence to support a serious allegation of sexual abuse, it will find that the prosecution failed to meet the standard of proof regardless of how the standard is actually formulated.

13. In light of these concerns, the Task Force has focused on how the standard of proof is stated applied in individual cases rather than on the articulation of this standard in the abstract. Not only will this approach avoid some of the legal difficulties outlined above, but more importantly, it may provide a more effective means of achieving the desired goal of improved enforcement of the College's prohibitions on sexual abuse by physicians.

(iii) Application of the Standard of Proof

14. While the law is settled with regard to the appropriate standard of proof in disciplinary proceedings, the application of this standard seems to be a somewhat more complex matter. In their text The Law of Evidence in Civil Cases, Sopinka and Lederman consider civil cases where evidence is subjected to special scrutiny, above and beyond the bare balance of probabilities. At p.390, the authors query: "In this class of cases how is the trier of fact to direct himself in the application of the standard of proof? In making a more critical appraisal of the evidence, is he not applying a higher standard than the ordinary civil

standard, and is the distinction between the criminal and civil standards a question of semantics?"

Sopinka and Lederman, The Law of Evidence in Civil Cases, (1974).

15. The Courts have gone to some length in attempting to distinguish between the application of the criminal standard and the application of the sliding civil standard of proof. See: Re Gillen and the College of Physicians and Surgeons of Ontario. In practice, however, the jurisprudence suggests that two factors have the greatest impact on the application of the sliding civil standard. It would seem that tribunals are most unlikely to render a finding of guilt (a) where a physician denies the conduct and adduces evidence as to good character in the community; and (b) where there is a lack of corroboration for the complaint. This observation is substantiated by the following excerpts from the Bernstein decision. O'Leary J. stated at 470-471:

> The grave charge against Dr. Bernstein could not be established to the reasonable satisfaction of the committee by fragile or suspect testimony. The evidence to establish the charge had to be of such quality and quantity as to the lead the committee acting with care and caution to the fair and reasonable conclusion that he was guilty of the charge. In this case where Dr. Bernstein, a man of good reputation swore that no impropriety occurred between himself and Joanne Johnston it would take very strong evidence to destroy his defence of his reputation.

At 486, Garrett J. made this comment:

> I am not prepared to hold that even though this is a sexual case that corroboration was required although I do think that the complete absence of any evidence at all confirming the complainant's evidence is a serious factor for the tribunal to consider and I would think that it would only be in the rarest cases that a finding of guilt would be made in these circumstances.

It is evident that in order to bring about a change in the application of the standard of proof, the probative value of character evidence and the need for corroboration must be addressed. These two issues will be treated separately below.

> Re Gillen and the College of Physicians and Surgeons of Ontario, supra.
> Re Bernstein and the College of Physicians and Surgeons of Ontario, supra.

(2) EVIDENCE

(a) Character Evidence

16. As noted in chapter 6 of the Task Force's final report, the Ontario Court of Appeal has recently dealt with the issue of character evidence in R. v. Millar. In that case, the Court of Appeal held that evidence of good character can serve two purposes: (a) as the basis of an inference that the accused is unlikely to have committed the crime charged, and (b) to support the credibility of the accused. In the decisions to date, it is difficult to ascertain whether the Discipline Committee employs evidence of good character as tendered by doctors for both of these purposes or for one rather than the other.

R. v. Millar (1989), 49 C.C.C. (3d) 193 (Ont. C.A.).

17. Recommendation 44 may effectively counter the first use of character evidence identified in Millar, i.e. the use of good character evidence as an indication of a lack of propensity for the accused to commit the offence in question. The Task Force indicated that there is data to show that evidence of good character does not have any bearing in the propensity of an individual to abuse patients sexually. Indeed, there is evidence to suggest that abusers often build good character profiles to camouflage their abuse. The Task Force therefore recommended that when defense counsel puts forward good character evidence, the prosecution should offer to the panel expert evidence that testimony to good character in areas of professional and community life does not have any bearing on the propensity to abuse sexually, and is therefore irrelevant to issues of guilt or innocence.

18. This recommendation should go some way towards improving the way in which tribunals apply the standard of proof in individual cases. It should nevertheless be noted that at some point defense counsel for the doctors will likely commission experts to develop data which will contradict the expert evidence of the prosecution on this point. Such a confrontation of experts is largely inevitable and does not seriously undermine the value of Task Force's recommendation. The suggestion that the propensity to commit sexual abuse is unrelated to other aspects of an individual's reputation seems to strike many people as a matter of common sense. The use of expert evidence to support this sentiment can only assist in the prosecution of abusers, even if contradicted by other expert testimony. This would be particularly true if the studies referred to by the Task Force were carried out independently.

19. A more difficult issue is presented by the use of good character evidence to support the general credibility of the accused. Such use of character evidence will always bear some weight in the mind of a trier of fact, particularly where it is supported by the demeanour of the accused during the hearing and the general context of the case. It is difficult to contemplate a means to counter such use of good character evidence. Appellate courts tend to exercise great deference to judgments of credibility made by triers of fact, largely because they are in the best position to make such conclusions. Consequently, it may be unwise to

attempt to constrain the ability of the trier of fact to assess the general credibility of witnesses by artificially limiting the weight to be placed on good character evidence.

(b) Corroboration of Complaints

20. All of the jurisprudence dealing with the standard of proof in discipline hearings indicates that the corroboration of a complaint is one of the most determinative factors in a prosecution for sexual abuse. A move away from the need for corroboration was made by Van Camp J. in the College of Physicians and Surgeons of Ontario v. K. Her Ladyship stated that a panel of the Discipline Committee can rely on the evidence of the complainant alone in the face of a physician's denial in a sexual impropriety case. However, Van Camp J. dissented in that case. The majority did not comment on this point and their decision was subsequently overturned by the Court of Appeal. In the Court of Appeal decision, there was no specific comment on the issue of corroboration although the court did urge appellate courts to treat the factual findings of discipline committees with deference.

> College of Physicians and Surgeons of Ontario v. K. (1985), 50 O.R. (2d) 14 (Div. Ct.).

21. In view of the current state of the law, there appears to be considerable merit in the recommendation for the drafting of a legislative amendment which would expressly authorize a panel of the Discipline Committee to act without corroboration in sexual abuse cases. Such an enactment may influence the application of the standard of proof by the Discipline Committee and send a signal to appellate courts to exercise greater deference in reviewing the findings of the Discipline panels in these cases.

(3) BIAS

22. People appearing before administrative tribunals have the right, in accordance with the principles of natural justice, to expect the trier of fact to determine their claim fairly and impartially. This is almost certainly a principle of fundamental justice under s. 7 of the Charter. This concept is also articulated in the administrative law prohibition against bias. It is likely that any case law concerning s. 7, "fundamental justice," and "bias" will mirror closely the existing jurisprudence which has developed in the administrative law area.

> Singh v. Minister of Employment & Immigration, [1985] 1 S.C.R. 177;
> Pearlman v. Manitoba Law Society (unreported decision of the S.C.C., released Sept. 26, 1991)

23. The current Canadian test for bias was set out in Committee for Justice and Liberty v. National Energy Board, [1978] 1 S.C.R. 369 at 394:

> ...the apprehension of bias must be a reasonable one, held by reasonable and right-minded persons, applying themselves to the question and obtaining thereon the required information....the test is 'what would an informed person, viewing the matter realistically and practically - and having thought the matter through - conclude. Would he think that it is more likely than not that Mr. Crowe, whether consciously or unconsciously, would not decide fairly.'

In this formulation, actual bias need not be proved - only a "reasonable apprehension of bias", but that apprehension must be "substantial" (at 395).

> Consolidated Bathurst Packaging v. I.W.A. (1990), 68 D.L.R. (4th) 524 (S.C.C.)
>
> Old St. Boniface Resident Association Inc. v Winnipeg (City), [1990] 3 S.C.R. 1170

24. Administrative tribunals generally do not have the same standards as courts. Members of administrative tribunals are not (usually) judges, and may be chosen precisely for their particular knowledge, experience and training. The principles of fundamental justice and bias are context-dependent, and may differ even among various tribunals.

> Committee for Justice and Liberty v. N.E.B., supra
> Pearlman v. Manitoba Law Society, supra

25. Applying the "reasonable apprehension of bias" test, any attempts at "stacking" (i.e., statutorily mandating that a majority of members be of a certain type or class) would probably appear, to a reasonable person, to constitute bias (regardless of whether any actual bias exists). But the Complaints and Discipline Committees are already "stacked" with persons of particular knowledge, experience and training - i.e. mainly doctors. This is not actionable bias.

26. Most of the reported caselaw where bias was alleged deals with actions of individual tribunal members (i.e., hearing their own appeal, having a monetary interest, etc.). Absent any specific actions of the tribunal members demonstrating that they cannot adjudicate the accused's claim fairly (or so it would reasonably appear to a reasonable person), the bias prohibition is unlikely to be triggered merely by their gender, race, training, etc.

27. In an area as highly gender-specific and politically charged as sexual assault and impropriety, one may argue that the mere gender of Discipline Committee members appears (to a reasonable person) to bias them towards the complainant or accused, as the case may be. However, if the members of the Committee are chosen on the basis of expertise and experience, and it can be shown that being female, and being trained/experienced in the area of sexual abuse does have a direct link to expertise (i.e., on sentencing decisions, etc.), the bias argument should fail. Presently, the only "expertise" Discipline Committee members

bring to the panel is their "expertise" at being doctors. While this may be highly important in competency hearings, etc., its effectiveness in sexual abuse cases is debatable.

28. Increasing the number of women on the Complaints and Discipline Committees will redress the current gender imbalance in the membership of these committees, and will better reflect the make-up of society in general, as well as of the pool of complainants. Although this recommendation may create some risk of a finding of bias, redressing an imbalance, when seen in the context of progressive action, will not necessarily swing the pendulum from fairness over the line into unfairness.

s. 15(2), Canadian Charter of Rights and Freedoms

29. In the event the Charter applies to proceedings of the Discipline and Complaints Committee (it clearly does apply to judicial review proceedings), an allegation of bias may support a claim under s. 15. However, even in criminal proceedings, where the Charter clearly applies, bias claims on the basis of gender or other personal characteristics have not been upheld.

Criminal Code, s. 626(2), no person disqualified or exempted from serving on jury on the grounds of his or her sex;

R. v. Kent, Sinclair and Gode (1986), 27 C.C.C. (3d) 405 (Man. C.A.)

30. To assert that training and expertise would bias the members of the Discipline or Complaints Committee toward the complainant is to ignore the fact that, as doctors, most of the members' training and expertise has been the same as the accused's. Yet this is not seen to disqualify them from sitting on these Committees - such commonality is the essence of peer review, the foundation of any self-regulatory profession. The presence of lay people (public members) on the Committees is in keeping with the government's agenda of opening up the accountability of the self-regulatory process. Moreover, to suggest that the members cannot be educated on new issues, research, and studies in the area of sexual abuse/impropriety without becoming "biased", is to call into question the whole concept of continuing education for the judiciary and the profession as a whole.

Regulated Health Professions Act, s. 24(2) and 37(2), Procedural Code

(4) INTERVENORS

31. The word "intervenor" encompasses a wide range of participation in the hearing, from the full rights of a party ("intervention as an added party") to something less ("intervention as a friend of the court"). A "party" under the Statutory Powers Procedure Act. R.S.O. 1980,

c. 484. s.10, which applies with modifications to CPSO disciplinary hearings, may call evidence, cross-examine witnesses, present argument, and appeal or apply for judicial review of an adverse ruling.

32. Patients even now are sometimes granted "intervenor status" by the panel, subject to restrictions on the form of their participation. Under the Human Rights Code, by comparison, a complainant has full party status, along with the "prosecuting" Commission, which has carriage of the case. In the criminal process, the victim has no independent standing in the prosecution. While CPSO hearings lie somewhere between the two models, it is submitted that the closer analogy is to proceedings under the Human Rights Code.

> Human Rights Code, 1985, S.O. 1981, c.53, s. 38(2)

33. Intervention is typically justified on one of two grounds:

> (a) that the intervenor has an interest in the subject matter of the proceedings in the sense that he or she may be adversely affected by the outcome; or
> (b) that the intervenor, as a friend of the court, has an interest in the development of the law in the area.
>
> Paul R. Muldoon. Law of Intervention: Status and Practice (1989, Toronto, Canada Law Book).

34. The benefits to the intervenor, or society, of the intervention must nevertheless be weighed against the possible prejudice to the party being intervened against.

> General Dynamics v. Veliotis (1987), 61 O.R. (2d) 111 (Div. Ct.), leave to appeal refused (1987), 21 C.P.C. (2d) 169n (C.A.).

35. Complainants under the Human Rights Code have a direct monetary interest in the outcome, as the Code provides for both restitution and damages for mental anguish. The alleged victim in a CPSO disciplinary hearing may have an indirect monetary interest in the outcome, if evidence of the physician's conviction is admissible in subsequent civil proceedings, as well as a possible interest through the proposed compensation fund. In any case, the complainant is likely to have a considerable emotional stake in the outcome.

36. The essence of the argument in favour of intervention is that it will likely lead to a better decision by bringing to the tribunal's attention all the interests involved, and all the arguments that can be made. The essence of the argument against intervention is that it will prejudice one or more existing parties either through delay (which increases costs) or through a procedurally unfair "ganging" up on one of the parties.

37. Provided that the negative aspects of intervention can be dealt with by appropriate procedural rules, such as the admissibility of evidence based on relevance, assigning carriage of the case

to the CPSO (thus avoiding "two prosecutors"), rules regarding costs, and ensuring the impartiality of the tribunal, allowing complainant intervention in C.P.S.O. disciplinary proceedings does not appear to infringe a known principle of fundamental justice.

38. Intervention in disciplinary hearings also raises non-Charter issues, including:

(a) whether the intervenor, as an added party, would thereby be required to submit to disclosure;
(b) whether the intervenor should be allowed to participate without representation by counsel. This difficult question is necessary to consider because of the risk that the intervenor's conduct, and the panel's reaction to it, may result in reviewable errors of law; and
(c) the extent to which the intervenor should be required to bear the burden of the extra costs due to the inevitable prolongation of the hearing.

These issues are likely resolvable through the development of a protocol for interventions.

39. A complainant who has been granted intervenor status will, of course, have no more claim to disclosure than any other participant in the proceedings. There being no common law right to disclosure, any such claim must be created by statute or under the Charter. Should the intervenor be added as a full party, s. 8 of the Statutory Powers and Procedures Act, which grants a "party" whose good character, propriety of conduct, or competence is in issue a right to prior notice of the allegation together with reasonable information pertaining thereto, may allow the complainant to discover the accused, on the basis that the defence will likely be based on the complainant's credibility or competence.

CHAPTER 11 - THE CASE FOR REGULATION: CONSTITUTIONAL JUSTIFICATION

1. In the event that any of the recommendations advanced by the Task Force on Sexual Abuse are found to be in violation of one of the enumerated rights or freedoms under the Charter, the Recommendations may nevertheless remain legally valid because they are justified under s. 1. Section 1 of the Charter provides as follows:

> 1. The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

2. If a challenger can establish in court that a recommendation of the Task Force is in violation of one of the enumerated rights or freedoms, the onus of proving that the Recommendation is justified under s. 1 would rest upon the College of Physicians and Surgeons of Ontario. Many of the other memoranda deal with whether the Recommendations of the Task Force are vulnerable to legal challenge under the Charter of Rights. Even if certain Recommendations are vulnerable to Charter challenge, as long as the College is motivated by purposes which are important and as long as the particular Charter infringement is not too severe, sound arguments would appear to be available to the College in favour of justification under s. 1 of the Charter.

Hunter v. Southam Inc., [1984] 2 S.C.R. 145, at p. 169.
R. v. Oakes, [1986] 1 S.C.R. 103, at pp. 136-137.

(1) "PRESCRIBED BY LAW"

3. Section 1 of the Charter provides that only a limit on rights or freedoms which is "prescribed by law" can be justified under this section. As a preliminary matter, the College must therefore establish that the instruments which enact the Task Force recommendations constitute "laws" for the purposes of the "prescribed by law" requirement.

4. At the present time, there is some uncertainty with regards to the means by which the Task Force recommendations will be enacted. Should the College choose to implement the recommendations by statutory amendment to the Health Disciplines Act or pursuant to regulations thereunder, they would clearly meet the "prescribed by law" requirement. The Supreme Court held in R. v. Therens, that a limit is prescribed by law if it is expressly provided for by statute or regulation, results by necessary implication from the terms of a statute or regulation or from its operating requirements, or is supported by the common law.

Health Disciplines Act, R.S.O. 1980, c. 196.
R. v. Therens, [1985] 1 S.C.R. 613.
Irwin Toy Ltd. v. Quebec (Attorney General), [1989] 1 S.C.R. 927.

5. It would also seem that the implementation of the recommendations by internal directive would meet this threshold requirement. In Slaight Communications Inc. v. Davidson, the Supreme Court of Canada found that an order issued by an adjudicator acting under statutory authority constituted a form of "law" for the purposes of the "prescribed by law" requirement. Like the adjudicator in Slaight, the College of Physicians and Surgeons of Ontario is a statutory creature operating under the purview of the Health Disciplines Act. The power to make internal directives is conferred upon the College in the form of a general discretion to regulate the medical profession. Given that the Health Disciplines Act confers an imprecise discretion and does not confer the power to limit the rights guaranteed by the Charter, it is possible to subject the exercise of this discretion, rather than the governing legislation itself, to the test set out in s. 1 of the Charter. In light of this jurisprudence, it is likely that any such form of implementation adopted by the College would likely fall within the "prescribed by law" requirement.

Slaight Communications Inc. v. Davidson, [1989] 1 S.C.R. 1038.
Health Disciplines Act, R.S.O. 1980, c. 196.

(2) THE TEST FOR JUSTIFICATION

6. Assuming that the College is able to establish that the Task Force recommendations are prescribed by law, it must meet the classic test for justification enunciated in R. v. Oakes. The majority of the Supreme Court of Canada adopted the following test in Oakes:

> (1) the objective, which the legislation in issue is designed to advance, must be "of sufficient importance to warrant overriding a constitutionally protected right or freedom"; and
>
> (2) a three-fold proportionality test must be satisfied:
>
> (a) the legislation must be rationally connected to the achievement of the objective in question - it must not be arbitrary, unfair or based on irrational considerations;
>
> (b) the legislation should impair as little as possible the right or freedom in question; and
>
> (c) there must be a proportionality between the effects of the legislation which is responsible for limiting the Charter right or freedom and the objective which has been identified as having sufficient importance.

R. v. Oakes, [1986] 1 S.C.R. 103, at pp. 138-140.

7. The test for justification enunciated in Oakes provides the basic framework for s. 1 argumentation and this case will structure the discussion herein. Applied strictly, the criteria

set out in Oakes represent a very demanding test for justification. The Supreme Court of Canada stated in that case that the issue of justification is to be assessed "objectively" and not from the standpoint of legislators. Not only is the burden of proof placed upon the party seeking to uphold the impugned legislation, this burden must be discharged with persuasive and cogent evidence.

8. Although the test in Oakes continues to provide a basic framework for s. 1 argumentation, it is important to recognize that the Supreme Court of Canada has moved away from this stringent standard of justification in many recent decisions. Over the course of the last few years, the Court has endorsed a "flexible approach" to s. 1 analysis which would allow for a tailoring of judicial scrutiny as warranted by the context of particular cases. In cases where socio-economic legislation is impugned, the Court has applied the justification test in a less demanding way because a perceived need to afford the legislature room to manoeuvre or a certain amount of leeway in dealing with such matters.

> R. v. Edwards Books and Art Ltd., [1986] 2 S.C.R. 713, at 795.
> Black v. Law Society of Alberta, [1989] 1 S.C.R. 591.
> Edmonton Journal v. Alberta, [1989] 2 S.C.R. 1326, per La Forest J. (dissenting).

9. The Supreme Court has also indicated that the test for justification ought to be approached with "flexibility" and "reasonableness" in mind. In United States v. Cotroni, La Forest J., writing for the majority of the Court, held that a "mechanistic approach must be avoided" and that in the s. 1 test "the underlying values must be sensitively weighed in a particular context against other values of a free and democratic society sought to be promoted by the legislature." He observed that the language of the Charter "invites a measure of flexibility".

> United States v. Cotroni, [1989] 1 S.C.R. 1469, at 1489-1490.
> Jones v. The Queen, [1986] 2 S.C.R. 284, per La Forest J.
> Reference re ss. 193 and 195.1(1)(c) of the Criminal Code, [1990] 1 S.C.R. 1123.

10. In Irwin Toy Ltd. v. Quebec (Attorney General), the Supreme Court drew an important distinction between cases where the government is attempting to mediate between the interests of competing groups (where a less demanding justification standard is appropriate) and cases where the government is best characterized as the singular antagonist of the individual whose right has been infringed (where a more demanding justification standard is appropriate). Specifically, the Court ruled that a less stringent standard of justification ought to be applied where the objective of the legislation was the protection of a vulnerable group.

> Irwin Toy Ltd. v. Quebec (Attorney General), [1989] 1 S.C.R. 927.

11. The validity of the Irwin Toy distinction appears to be supported by the Court's decision in Rocket v. Royal College of Dental Surgeons. In this case, the Court considered whether restrictions on advertising by dentists could be saved under s. 1 of the Charter. It was observed that the public is more vulnerable to unregulated advertising of professional dental

services than it is to unregulated advertising of manufacturers or those who supply standardized goods and services. Consequently, McLachlin J. noted that some deference should be accorded to the legislature since it had intervened to protect a vulnerable group. However, the Court ultimately concluded that the restrictions were too broad and could not be justified under s. 1 of the Charter.

Rocket v. Royal College of Dental Surgeons, [1990] 2 S.C.R. 232.

12. The Irwin Toy position also received an endorsement in McKinney v. University of Guelph. In commenting on cases where the legislature has attempted to strike a balance between competing interests, La Forest J. stated at 69:

> They are decisions of kind where those engaged in the political and legislative activities of Canadian democracy have evident advantages over the judicial branch, as Irwin Toy, supra, at pp.993-94, has reminded us. This does not absolve the judiciary of its constitutional obligation to scrutinize legislative action to ensure its compliance with constitutional standards, but it does import greater circumspection than in areas such the criminal justice system where the courts knowledge and understanding affords it a much higher degree of certainty.

McKinney v. University of Guelph (1990), 45 O.A.C. 1 (S.C.C.) at 69.

13. Despite this trend in the jurisprudence, a caveat should be noted. The s. 1 doctrine is in a state of flux and the Court has not been consistent in its "flexible approach" to the justification test. In particular, three decisions handed down by the Supreme Court have cast considerable doubt on the distinction advanced in Irwin Toy. In two criminal cases where the state was the singular antagonist of the Charter complainant, the Court appears to have taken a less stringent approach to justification in circumstances where one would expect the judiciary to apply the Oakes test quite strictly: R. v. Lee; R. v. Chaulk. Yet in a case involving a contest between the interests of family law litigants in privacy and the interests of the public in being informed about court proceedings, the Court seemed to adopt a strict justification test: Edmonton Journal v. Alberta (Attorney General). It is evident that none of these decisions is entirely congruent with the distinction suggested by the Court in Irwin Toy.

R. v. Lee, [1989] 2 S.C.R. 1384.
R. v. Chaulk (1990), 62 C.C.C. (3d) 193 (S.C.C.).
Edmonton Journal v. Alberta (Attorney General), [1989] 2 S.C.R. 1326.

14. This general overview of the jurisprudence reveals that while a "flexible approach" will be taken to s. 1 analysis, it is difficult to determine how the test for justification will be formulated in particular cases. With these various trends in mind, the application of the test for justification to the recommendations of the Task Force can be considered.

(3) APPLICATION OF THE JUSTIFICATION TEST TO THE TASK FORCE RECOMMENDATIONS

(a) Objectives of Sufficient Importance

15. The first stage in the Oakes framework for s. 1 analysis relates to the objectives of the impugned legislation. The court must determine whether the legislative objectives are of sufficient importance to warrant overriding a constitutionally guaranteed right.

16. Throughout The Final Report of the Task Force on Sexual Abuse of Patients, it is clear that the primary objective of the recommendations is to protect members of the public from sexual abuse by physicians. In the Executive Summary of the Final Report, the Task Force explains that patients are a particularly vulnerable group:

> Patients seek the help of doctors when they are in a vulnerable state - when they are sick, when they are uncertain, when they are needy. The unequal distribution of power in the physician-patient relationship creates opportunities for sexual abuse. This vulnerability gives physicians the power to exact sexual compliance. Knives and guns and physical force are not necessary.

The actual harms suffered by those who have been sexually exploited by physicians are considerable. The damage can be physical, emotional and spiritual and the effects permanent. The Task Force indicated in its Preliminary Report that the incidence of abuse by physicians can be approximated at 10% and thus, such abuse represents both a serious and a widespread problem. This conclusion has been reinforced by the most recent survey conducted by The Canadian Health Monitor (September, 1991) indicating that 8% of women patients have reported experiences of abuse by a doctor.

17. In light of all these factors, an attempt by the state to protect vulnerable persons from such abuse manifestly constitutes a pressing and substantial objective.

> Irwin Toy v. Quebec (Attorney General), supra.
> Rocket v. Royal College of Dental Surgeons, supra, per McLachlin J.
> Slaight Communications Inc. v. Davidson, supra, per Dickson C.J.C.

(b) Proportionality

(i) Rational Connection

18. The rationality requirement constitutes the first part of the three-fold proportionality test. Seldom has the Court found that the means adopted in legislation are not rationally connected to the objective of the legislation. Impugned legislative provisions will not meet this requirement where they are arbitrary, unfair or based on irrational considerations.

David Stratas, Charter of Rights in Litigation (1990) at para. 6-16.4.
R. v. Morgentaler, [1988] 1 S.C.R. 30.
R. v. Keegstra (1990), 61 C.C.C. (3d) 1 (S.C.C.).

19. There is little doubt that the various recommendations put forward in the Final Report are rationally connected to the objective of protecting patients from sexual abuse by physicians. The recommendations can be loosely grouped into three subject areas: improved education about sexual abuse; increased severity of penalties for sexual abuse; and improved enforcement of the prohibitions on sexual abuse by physicians. Given that these Recommendations show care in design, lack arbitrariness and further an important legislative aim, it seems likely that these provisions would pass this branch of the proportionality test.

Canada (Canadian Human Rights Commission) v. Taylor (1990), 117 N.R. 191 (S.C.C.).

(ii) Minimal Impairment of the Right

20. The second part of the three-fold proportionality test is the requirement that an impugned provision impair a right as little as possible. Interpreted strictly, this requirement would place a very heavy burden on a party seeking to uphold legislative initiatives under s. 1 of the Charter. However, recent jurisprudence indicates that this branch of the proportionality test has been applied in a less demanding or "flexible" fashion from time to time. The governmental body is given some leeway under this branch of the justification test.

21. In Black v. Law Society of Alberta, La Forest J., writing for the majority of the Supreme Court of Canada, indicated his endorsement of a less demanding or flexible approach to the minimal impairment test:

> The legislature must be given sufficient scope to achieve its objective. As I noted in R. v. Edwards Books and Art Ltd., at p. 795, in struggling with the questions of social policy and attempting to deal with conflicting pressures, "a legislature must be given reasonable room to manoeuvre...". The term "reasonable limit" is used in s.1 and must be given meaning. Inherent in the word "reasonable" is the notion of flexibility. S. 1 does not advocate perfection.

Black v. Law Society of Alberta, [1989] 1 S.C.R. 591, at 627-628.

22. As noted above, the Supreme Court applied the minimal impairment test in a less demanding manner in Irwin Toy Ltd. v. Quebec (Attorney General). The majority of the Court emphasized the need to exercise deference in the face of legislative initiatives which aim to protect vulnerable groups:

> When striking a balance between the claims of competing groups, the choice of means, like the choice of ends, frequently will require an assessment of conflicting scientific evidence and differing justified demands on scarce resources. Democratic institutions are meant to let us all share in the responsibility for these difficult choices. Thus, as courts review the results of the legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of the legislature's representative function.

It should, however, be recalled that the Court in Irwin Toy maintained that this less demanding application of the minimal impairment test would be inappropriate in a case where the state is best characterized as the singular antagonist of the individual whose rights have been infringed.

> Irwin Toy Ltd. v. Quebec (Attorney General), supra, at 993.

23. In view of this jurisprudence, the likelihood that certain Task Force recommendations will satisfy the minimal impairment test in s. 1 may depend on whether they will be subject to the strict test which is imposed where the state is the singular antagonist of the individual or whether they will be subject to the more deferential test, which is imposed where the state intervenes to allocate scarce resources between competing social groups or protect vulnerable groups?

24. In exercising its prosecutorial powers, there is little doubt that the College carries out what some regard as a quasi-criminal function. Under the recommendations of the Task Force, the Discipline Committee of the College can find medical practitioners to be guilty of sexual abuse and order the payment of fines and the revocation of the licence to practice. In seeking to change some aspects of the College's disciplinary procedures, certain recommendations are likely to have important effects upon individuals appearing before the College. However, it must be emphasized that these procedures are related to quasi-criminal proceedings and not prosecution under criminal law and that there will always be important effects on individuals where bodies seek to protect vulnerable groups. For these reasons, it is not clear that the College, acting in this capacity, is best characterized as the singular antagonist of the individual whose right has been infringed.

25. While the College can mete out serious penalties, it should be emphasized that this organization was established as a self-regulatory body designed to mediate between the professional interests of medical practitioners and the interests of the public in dealing with the medical profession. Medical practitioners have an interest in ensuring high standards of professional competency through licensing, registration and discipline procedures. They also have an interest in having such regulation carried out in a fair and impartial manner.

26. The prime interest of the public is in highly competent and ethical health care. The Task Force on Sexual Abuse has focused on one pressing aspect of this larger interest in competent health care: the prevention of sexual abuse by medical practitioners. Its recommendations

are premised upon a recognition that the unequal distribution of power in a physician-patient relationship creates vulnerability and opportunity for sexual abuse. The prime objective of the recommendations is to protect members of the public, especially vulnerable members of the public, from the devastating effects of sexual abuse. The recommendations are being advanced after careful study and within the context of an over-arching legislative scheme. In view of this attempt by the College to balance carefully complex interests and protect a particularly vulnerable group in society, a good case can be made for a less stringent application of the minimal impairment requirement.

27. In view of the serious consequences that may result from a prosecution for sexual abuse, some courts may prefer to characterize the College as the singular antagonist of the individual and apply the minimal impairment test strictly. The Task Force disagrees with this characterization. Nevertheless, even on such a test, a strong case could be mounted to justify rights infringements arising from the recommendations of the Task Force. Beyond the harm inflicted upon individual patients and the imbalance of power implicit in the offending conduct, it must be emphasized that sexual abuse by physicians is a widespread problem which is particularly difficult to detect and even more difficult to prosecute with any success. To this extent, it can be argued with some force that many of the recommendations advanced by the Task Force represent not only reasonable measures but also the only measures which will further the important objectives of the College while impairing the rights of alleged offenders as little as possible.

(iii) Proportionality Between Effects of Measures and Importance of the Legislative Objective

28. The third and final branch of the three-fold proportionality test is the requirement for proportionality between the injurious effects of legislation and the importance of the legislative objective. The Court has said little to explain its approach to this branch of the test, which appears to demand a balancing of benefits and detriments that cannot be fully articulated.

> David Stratas, Charter of Rights in Litigation, (1990) at para. 6-22.9.

29. Several cases illustrate the fact that the initial characterization of the legislative objective will have a significant impact on the Court's analysis of the balance between the injurious effects of legislation and the importance of the legislative objective. Where the underlying objective is found to be merely administrative convenience, it is very unlikely that this objective will outweigh the effects of a rights violation: R. v. Schwartz. Administrative convenience is an objective which does not underlie any of the Task Force Recommendations. In United States v. Cotroni, the majority of the Court held that the extradition of an accused who could have been prosecuted in Canada could pass this branch of the proportionality test. In coming to this conclusion, the Court placed considerable emphasis on the role of extradition in furthering co-operation and goodwill between different countries' investigative agencies.

Finally, in R. v. Lee, a provision of the Criminal Code section which resulted in the loss of trial by jury for those who failed to show up for their trial was examined. The Court ruled that the deleterious effects of the provision were outweighed by the underlying objectives of deterring accused persons from failing to attend trial and of securing respect for the criminal justice system.

R. v. Schwartz, [1988] 2 S.C.R. 443.
United States v. Cotroni, supra.
R. v. Lee, supra.

30. The decisions in Cotroni and Lee suggest that the violation of significant legal rights can be justified even where the legislative objective is not particularly compelling. In view of these holdings and the great importance of the legislative objectives underlying the Task Force recommendations, sound arguments can be made in favour of all of the Recommendations under this part of the proportionality test.

Additional Appendices to the Report

APPENDIX A - RE: RECOMMENDATION 24

The following draft amendment to Section 15 of the **Health Disciplines Act** has been developed by the Task Force to illustrate the degree of specificity required in order to ensure that any College decision to reinstate a member found guilty of Sexual Violation or to lift the suspension of a member found guilty of Sexual Impropriety is predicated on a thorough review of evidence and documentation from: the member applicant, the assessor who has reviewed materials and interviewed the applicant, expert witnesses and any other member of the College or any other individual who wishes to present information in person or in writing related to the application for reinstatement.

The Task force acknowledges that this draft amendment requires the attention of legislative counsel and that the **Health Disciplines Act** will soon be replaced by the **Regulated Health Professions Act**. However, the Task Force wanted to include an example of the detailed legislative amendment which is required to meet the standards of **Zero Tolerance**.

CONDITIONS FOR REINSTATEMENT OF MEDICAL LICENCE OR FOR LIFTING SUSPENSION OF LICENCE DUE TO SEXUAL ABUSE OF PATIENTS

The requirements for the issuing of a licence of <u>any class</u> to an applicant are that:

> where he or she has previously practised medicine and the evidence shows that there has been a finding of Sexual Violation or Sexual Impropriety or any like finding involving sexual misconduct or incompetence where the applicant's licence has been revoked or suspended, the applicant must satisfy the conditions for reinstatement as set out in these **Regulations**.

Where the Discipline Committee hears an application for reinstatement under the **Act**, and where the applicant has previously had his or her licence revoked or suspended for Sexual Violation or Sexual Impropriety or any like misconduct with a patient, the Discipline Committee shall not restore the applicant's licence until it is satisfied on the evidence before it that:

1) there is no possibility of the applicant abusing patients or other individuals in the future, and

2) re-admission would be in the public interest.

In making the determination, the Discipline Committee must be entirely satisfied, based on a review and examination of evidence, that the applicant has:

(a) caused a notice of application to be published by the College of Physicians and Surgeons within four weeks after the written application is filed, such notice reminding members of the College of the duty to report knowledge of sexual abuse by another member and outlining ways of contacting the College to ensure such information is reviewed by the College prior to the reinstatement hearing;

(b) demonstrated the ways that reinstatement would be in the public interest;

(c) acknowledged and understood the harm his or her misconduct has caused to the applicant's patients, family, friends and colleagues, including, but not limited to, evidence that any losses the applicant may have caused his or her patients have been made good, and evidence that the Survivors Compensation Fund has been reimbursed for all payments made from it in respect of sexual abuse by the applicant in addition to fines already paid;

(d) filed a statutory declaration setting out in full the applicant's business or employment activities during the period following the revocation of his or her licence;

(e) filed a certificate from his or her treating professional detailing the course of treatment entered into, and stating whether, in the treating professional's opinion, the applicant poses no danger to any future patients;

(f) filed a resumé of an external assessor skilled in the treatment of sexual offenders, and files a certificate from the external assessor detailing the course of the assessment and stating whether, in the assessor's opinion, the applicant poses no danger to any future patients;

(g) caused the treating professional and assessor to be available at the reinstatement hearing, where the Committee shall inquire of them recommended practice restrictions, if any, acknowledging that supervision of practice is not a sufficient safeguard;

(h) had the assessor complete a specific assessment related to understanding why the abuse occurred, and whether the conditions leading to this abuse might occur again should the physician be reinstated;

(i) had the assessor or treating professional determine specific rehabilitation goals, including standards to measure their achievement, and file a statement as to whether the applicant has complied with the rehabilitation plan, and has met all rehabilitation goals;

(j) had the assessor include specific changes in behaviour as part of the rehabilitation program, and file a statement as to whether that behaviour has changed and will continue to be changed in future;

(k) had the assessor prepare a re-entry plan for the physician, and file a statement that this plan included substantive safeguards including monitoring should the physician be reinstated, to prevent any further instances of sexual impropriety or sexual violation, and presented evidence that the safeguards will be effective in preventing further abuse;

(l) demonstrated a commitment to ongoing rehabilitation therapy, including concrete benchmarks for progress, changes in behaviour and practice style; submitting quarterly reports to the College on the status of their recovery progress; vocational counselling; and social restitution (i.e. participation in community service work, etc.); and,

(m) filed evidence of education and training sufficient to satisfy the standards of practice that will be met upon re-entry to practice.

Appendix B

LIST OF PRESENTERS AT PUBLIC HEARINGS

Hearing Date and Location	Presenter	Organization
February 19 Toronto		
	Allen MacDonald	VOICE (Victims of Infant Circumcision Enounce)
	Rose Nixon and Andy Stephens	Members, Native Community
	Don Moore	Citizen's Commission on Human Rights
	Dr. Sheila Dunn	Physician Sexual Assault Care Centre Women's College Hospital
	Martin Meslin	Former CPSO Council Lay Member
	Donna Lovell	Survivor of physician sexual abuse
	Jeri Wine Temi Firsten	CHASTEN (Canadian Health Alliance to Stop Therapist Exploitation Now)
March 16 Thunder Bay		
	Keith Ashford	Coalition Against Sexual Abuse of Children
	Josephine Mandemin	Beendigen Inc.
	Pru Morton	Patients' Rights Association, Thunder Bay Chapter
	Dr. Ken Arnold	Family physician
March 19 Ottawa		
	Michelle Hurtubise	Ottawa Rape Crisis Centre
	Rita Hughes-Cornish	House of Hope and Healing
	Ann Gleason	Survivor of physician sexual abuse
	Lynn Hamilton Kathleen Scott Kathleen Whipp	Sexual Assault Support Centre of Ottawa-Carleton
	Dr. Paul Cameron Dr. Walter Potozny	Department of Psychiatry, University of Ottawa Faculty of Medicine
March 24 Windsor		
	Dr. Eleanor Schumacher	Psychiatrist, Member of Essex County Medical Society
	Jean Halliwell	Survivor of physician sexual abuse
April 2 Toronto		
	Jane Richardson	Advocate, About Face

Hearing Date and Location	Presenter	Organization
	Dr. Marcellina Mian	Paediatrician and Director, Suspected Child Abuse and Neglect Program, Hospital for Sick Children
	Sylvia Bradley	Survivor of physician sexual abuse
	Heather Morris, Donna	Therapist, St. Jamestown Health Centre, The Wellesley Hospital, with a survivor of physician sexual abuse
April 7 North Bay		
	Alvina Neault	Mattawa Family Resource Centre
	Robin Hokstad Louise Wall Kimberley Williams	Pediatric nurses
	Sister Marilyn Duff William Brunton	Chairperson, St. Joseph's General Hospital of Bay Inc. and Chief Executive Officer, North Bay Civic Hospital
	Pam Alcorn Barbara Wellard	Nipissing Transition House
	Marie Marchand	Women's Action Committee of Nipissing
	Dr. Wendy Graham	Head of Family Practice and Chairperson, OMA Committee on Women's Health Issues
	Judy Howitt	Therapist who works with survivors of sexual abuse
	Dr. Joseph Madden	Paediatrician
	Alan Sparkes	Professor, Nipissing University College
April 16 Toronto		
	Cat Charissage	Executive Director, Sexual Assault Centre London
	Anne Coy	President, Patients' Rights Association
	Ann Josling	Survivor of physician sexual abuse
	Anne Molloy	Legal Counsel Advocacy Resource Centre for the Handicapped
	Mary Beth Valentine	Provincial Coordinator Psychiatric Patient Advocate Office
	David McCann	St. Joseph's and St. John's Training School for Boys Help Line
	Karlene Moore Deb Parent	Toronto Rape Crisis Centre
	Cynthia Roll	Survivor of physician sexual abuse
	Phyllis Curry	Consultant Addiction Impacted Families Foundation

Hearing Date and Location	Presenter	Organization
June 20 Toronto		
	Dr. John Gray Dr. Wendy Graham	Ontario Medical Association
	Vuyiswa Keyi	Health Promoter, "Women's Health in Women's Hands', A Community Health Centre for Women
	Marion Beauregard	Researcher and Doctoral candidate Ontario Institute for Studies in Education, Psychology
	Pat Israel	President, Disabled Women's Network Canada
	Ann Josling	Survivor of physician sexual abuse
	Laura Stermac, PhD Dr. Stephen Hucker	Clarke Institute of Psychiatry
	Dr. Patrick McQuade	Retired Physician
	Catherine Sutherland	Survivor of physician sexual abuse
	Phyllis Curry	Consultant, Addiction Impacted Families Foundation
	Sarah Morgan	Member, Self-Help Group for survivors of physician sexual abuse
	Dr. David Walker	Canadian Medical Association
	Barbara Thornber	Executive Director, Ontario Association for Community Living
	Shannon Buchan Karen Sandercock	Law students, National Association of Women and the Law, University of Western Ontario caucus
	Dr. Elaine Borins	Physician
	Dr. Lesbia Smith	Federation of Medical Women of Canada - Ontario Region
	Dr. Joan Down Dr. Denise Wexler	Female physicians in practice
	Dr. Anne Cox Dr. Jaga Iwenowska Dr. Florence Merredew	Professional Development Committee, The General Practice Psychotherapy Network

Appendix C

MEDIA RESPONSE TO THE TASK FORCE

Over the months that the Task Force has been working, media response to the initiative has been overwhelming. More than 150 interviews, news items and features have been done on the Task Force, many of them in the communities across Ontario where public hearings were held.

Part of the role of this Task Force has been to heighten public awareness of this issue, and encourage discussion about what needs to be done to end the sexual abuse of patients. The first step in ending abuse is to recognise that it exists, and the intensive media coverage that has followed our work has added tremendously to public education and debate.

FEATURE

McPhedran takes the stand

WITNESS FOR THE PROSECU

COMMENT

BY GORDON

Chilling, dangerous and unpalatable

Health law expert looks at sex abuse document

BY RICHARD SHEKTER



The Globe and Mail, Monday, July 29, 1991

Shattered Trust

Sexual abuse cases

Doctors: little question better controls needed

The vast majority of Ontario's doctors are, sadly, feeling the effects of a controversy surrounding the relatively few members of the medical profession who have abused patients during the last few years. Doctors are being tarred with the same brush.

The number of doctors involved in sexual abuse need to do so is believed headline: College of Physicians from medical

'Zero tolerance is encouraging'

It is very likely that Ontario doctors who sexually abuse patients will, in the future, lose their licences for life.

The College of Physicians and Surgeons of Ontario has not exactly been on the cutting edge of change. It has been unanimously endorsed a recommendation to this effect.

After four months of investigation, the task force, a special task force, has found some very disturbing findings. For example, there are more troubling was the conclusion that sexual abuse by doctors in Ontario have sexually abused patients. The units made by patients. The ... a system in which patients' complaints have been trivialized or ignored ... reality in Canada today is that a medical degree is one of the best ... way is more prevalent than the ... prevalent than the ... tered to admit. ... bridge, or ... based ...

Docs report on sex abuse

By RAY SMITH
Toronto Sun

Task force hears horror stories

Cont'd from page A1.

St. Joseph's General Hospital, ... the report Wednesday. ... have to take my review to ... members," she said. ... say com... ... this issue." ... expert at No... ... pital, Mark Ha... ... not to comme... ... the report.

years ago her family doctor ... spoons to a brown-feeding ... she had was to grab her ... kiss her while having an affair.

Comments to Mayor Row...

THE TORONTO ...

EDITORIALS

When patient... accuse doctor...

BACKGROUND / Psychological profile

Abusive doctors have many faces

BY PAUL TAYLOR
Medical Reporter

DOCTORS who had sexual relations with patients have often been portrayed in books and movies as hard-working professionals who succumbed to the charms of a seductive woman.

But the testimony of women who have ... doctors' image. ... Some ... disturb... with h... might ... of th... prof... with ... con... ow...

...tims are can... vulnerabili... that the w... authorit... make th... Charg... contro... know... ual ac... "The ... legs ...

No room in medicine for doctors who betray trust

While the standards may ... on sexual ... ented to the Ontario col... lege this week.

But it is difficult to ac...

Women tell their stories

When healers betray the

By ANDREW DRESCHEL
The Spectator

SHE WAS 19 or 20 at the time, living in Guelph and working at the university there. She went to a dermatologist because of an ... discomfort was never to go back to him again. I had no idea what to do or what to say, but I knew that I couldn't go back," she recalls.

That's one anecdote. And in Canada, because of a lack of studies tracking sexual abuse and exploitation of patients by doctors ...

No tolerance for abusers

Preying on patie...

A BREACH OF TRUST

Report on sex abuse by doctors expected to recommend overhaul of complaint proce...

BY SHARON KIRKEY

A ... told his patient ... that unless ... than ...

TREATMENT / *Physicians argue that doctors who abuse patients have a right to redeem themselves, but not everyone believes sexual offenders can be reformed*

MDs don't like 'cure' for abusers

BY PAUL TAYLOR
Medical Reporter

ONCE a sex abuser, always a sex abuser?

That is the question faced by a task force delving into ...

The Ontario Medical Association, which represents the political and professional interests of the province's 22,000 physicians, has made it clear it is not pleased with the proposed lifetime ban for sex offenders.

... being taught.

"We heard from the victims of doctors who already had been found guilty of sexual abuse by the college, disciplined, and returned to practice," Ms. McPhedran said.

Doctors who abuse patients pose rehabilitation questi...

From Page A1

In recent years, researchers have developed elaborate methods of categorizing different types of sexual offenders. But such diagnostic ... will do not give them any ... consistently alter their ... may appear to be ... who back to ...

OMA gives ... ban for MDs' b...

Toronto lawyer and chairman ... task force, noted that no expert ... ness has yet come forward with evi... dence that sexual offenders can be rehabilitated with any certainty, so ... patients could still be at risk of sex... ual abuse when a convicted doctor returned to practice.

Ms. McPhedran acknowledged that she fears a mandatory lifetime ... can might make the college's disci... ...ary committee reluctant to find ... ors guilty of sexual abuse. ... are struggling for answers. ...

Dr. Gray began by saying the association agrees with the ... force's philosophy of "zero tolerance" for sexual activity between physicians and patients. But he said guilty ... be given a chance ...

Denounces proposed lifetime ban for sexual abuse

BY PAUL TAYLOR
Medical Reporter

TORONTO — The Ontario Medical Association has denounced a proposal to impose a lifetime ban on practising medicine for doctors found guilty of sexually abusing patients.

... which represents ... professional inter... ...000 physi... that ...

LETTERS TO THE EDIT...

...red of sexual harass...

Abusive therapists hide behind the system

...e 15, 1991

...ent

...ue entirely to the fact that ...ed the patient female. He ... with excuse and legitimize ... a biological basis. The ... condoned and encou... under which say ... their positi... but women ... to ... abused ... that everyone's had a quick ... course in sexual harassm... so the perfect time ... meeting. I had ... women ...

...he reasons why some doctors sexually exploit their patients are many and complex. A physician ha... ...nerable, trusting women. He's an authority figure and temptation can be a tenacious ailment

...tation: why doctors do it

Ontario Medicine

PUBLICATION FOR ONTARIO'S PHYSICI...

Lifetime bans called too severe

... abuse task force proposals severe — Algom...

Appendix D

REPORT OF THE ADVISORY COUNCIL TO THE TASK FORCE ON SEXUAL ABUSE OF PATIENTS

Background:



Dr. Joan Bain, Chairperson, Advisory Council

The Advisory Council to the Task Force on Sexual Abuse of Patients was established to provide the Task Force with expert input, to discuss and debate significant issues around sexual exploitation of patients, to act as a sounding board for the Task Force during the development of its recommendations and to provide a forum for an exchange of views among representatives from a wide range of organizations, interest groups and individuals with experience in this field.

From February of 1991 through the summer, the Advisory Council met on a monthly basis and undertook a series of initiatives. These included a review of Task Force planning for community outreach; an educational workshop involving the Advisory Council, the Task Force, members of the College of Physicians and Surgeons Council and lawyers who act for the College in discipline cases; a series of consultations with College staff, Council members and the College's Education Committee; and a review of the draft recommendations of the Task Force.

Biographical Sketches:

The 22 members of the Advisory Council were chosen for their experience in the area of sexual abuse and the range of perspectives they brought to this complex issue. Some were drawn from the medical profession, others from government, community groups and public interest groups.

Ms. Mary Addison
Director of the Sexual Assault Care Centre and the Department of Social Work at Women's College Hospital.

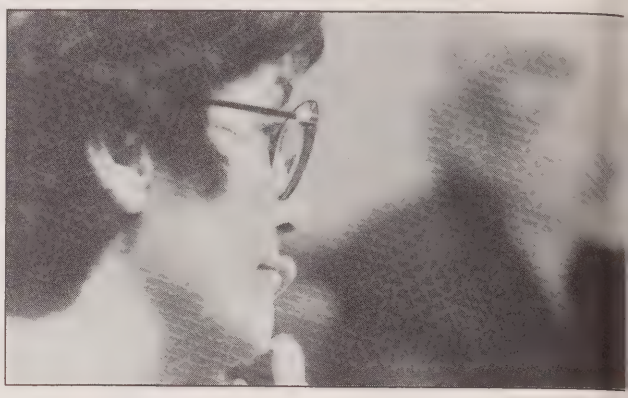
Ms. Sue Anderson
Ontario Native Women's Association - Secretary & Guest Speaker on Native Concerns.

Dr. Joan Bain
Co-Chair, Metro Toronto Committee Against Wife Assault; Past OMA Board Member; Past-President, the College of Family Physicians of Canada; Chair, National Advisory Council on Family Medicine Training.

Dr. Carole Clapperton
Family physician; President of the Ontario College of Family Physicians of Canada; former physician to the maximum security prison for women at Kingston.

Dr. Jim Curtis
Internist; member of the College of Physicians and Surgeons of Ontario Council and the Discipline Committee.

Dr. Christine Dunbar
Psychiatrist in private practice; representative of CHASTEN (one member of this group attends a Council meeting).



Dr. Rebeka Moscarello, Psychiatrist, Women's College Hospital

Ms. Temi Firsten
Social Worker, Sexual Assault Care Centre, Women's College Hospital; Coordinator of the Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN).

Dr. Graham Glancy
In private practice; former Chief of the Forensic Service, Clarke Institute of Psychiatry, providing education for physicians and research and treatment programs for offenders.

Dr. Kristel van Ineveld
Executive member of the Professional Association of Interns and Residents of Ontario; member of the Physicians-at-Risk Committee.

Ms. Pat Israel
National President, Disabled Women's Network Canada (DAWN).

Dr. Gary Johnson
Anaesthetist, University of Ottawa; Council Member and Education Committee Member of the College of Physicians and Surgeons of Ontario.

Dr. Barbara Lent
Family Physician; member of the London Coordinating Committee to End Woman Abuse; member of the O.M.A. Committee on Wife Abuse; Principal Author of "Wife Assault: A Medical Perspective."

Ms. Judie McSkimmings
Public Education Coordinator, Ottawa Rape Crisis Centre: front line worker with sexual abuse survivors and experience in the health care field; lay member of the governing council of the College of Physicians and Surgeons.

Ms. Eleanor Meslin
Assistant Deputy Minister, Corporate Services Division, Ministry of Consumer and Commercial Relations; former Assistant Deputy Minister of the Ontario Women's Directorate.

Dr. Marcellina Mian
Paediatrician; Director of Suspected Child Abuse and Neglect (S.C.A.N.) Program at the Hospital for Sick Children; Past-President of the Metropolitan Toronto Special Committee on Child Abuse.

Dr. Rebeka Moscarello
Psychiatrist, Women's Health and Sexual Assault Care Centre, Women's College Hospital.

Ms. Diane Nannarone
Senior consultant, Women's Health Bureau, Ministry of Health; five years experience with victims of sexual abuse.

Ms. Aruna Papp
Consultant, Multicultural Community Development and Training; Domestic Violence Counsellor.

Dr. Gail Robinson
Psychiatrist and Co-Head, Program in Women's Mental Health, Department of Psychiatry, University of Toronto; METRAC Board member.

Ms. Judy Shanks
Executive Director, Canadian Mental Health Association, Timmins Branch.

Dr. Lana Stermac
Psychologist, Clarke Institute of Psychiatry and private practice; clinical and research work in adult and child sexual abuse.

Dr. Allan Torrie
Physician, Lake of the Woods Hospital, Kenora; experience in rural and northern practice and with Native communities.

Areas of Discussion:

The Advisory Council meetings were attended by some College staff and by the Task Force members, who raised issues of concern with the Council as their public and private hearings proceeded. Included in the issues discussed by the Advisory Council were:

1. How can the immigrant community be made aware of the hearings and how can they be assisted to overcome language barriers at the hearings?

   Following discussion of this issue, a decision was taken to translate Task Force material into ten languages, distribute this material through ethnic organizations and make translations services available at the hearings on request.

2. What is available as support or follow-up for those who come forward?

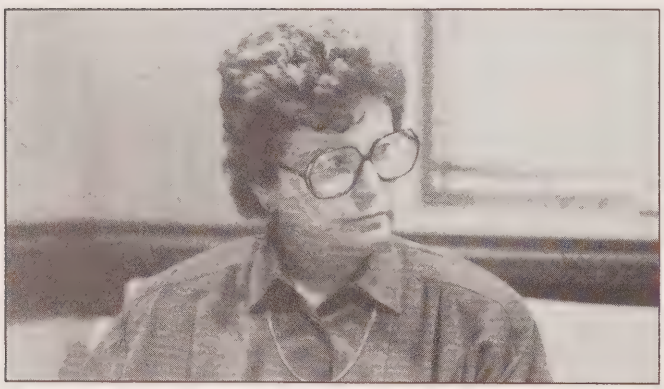
   Arrangements were made to have a College complaints officer present should any presenter wish to file a complaint. At some hearings, volunteers from rape crisis centres were available before and after the hearings to support those coming forward. Callers to the Task Force who expressed a desire to seek counselling were offered help to find appropriate resources in their communities, although the support net work was found to be completely overburdened in all areas of the province. At the request of the Task Force and some presenters at public hearings, the College undertook to meet with government and raise the concern of inadequate resources to counsel victim survivors of sexual abuse by physicians.

3. What about disabled people who are sexually abused?

   A representative from the disabled community sat on the Advisory Council. Signage was available at a number of the public hearings, and all avenues for public hearings were wheelchair accessible.

4. How can the needs and perceptions of the disabled, the aboriginal groups and the immigrant women's community be addressed, and what cultural barriers to counselling and services exist?

   This question was addressed a number of times in meetings of the Advisory Council and in the educational workshop session. Ideas and concerns were also raised by presenters to the Task Force representing these groups.



Eleanor Meslin, Ontario Women's Directorate

The importance of outreach to various communities was identified early on by the Advisory Council, and a subcommittee was established to work on outreach to immigrant women and other key groups. Ms. Eleanor Meslin offered the assistance of the Ontario Women's Directorate in this effort. The subcommittee included Eleanor Meslin, Aruna Papp, Diane Nannarone and Pat Israel. The Advisory Council considered and shared its knowledge of possible support and resource networks in the community. A number of individual members of the Council volunteered to return some calls to the Task Force personally as the volume and impact of the telephone calls and private disclosures became more and more overwhelming for the Task Force members.

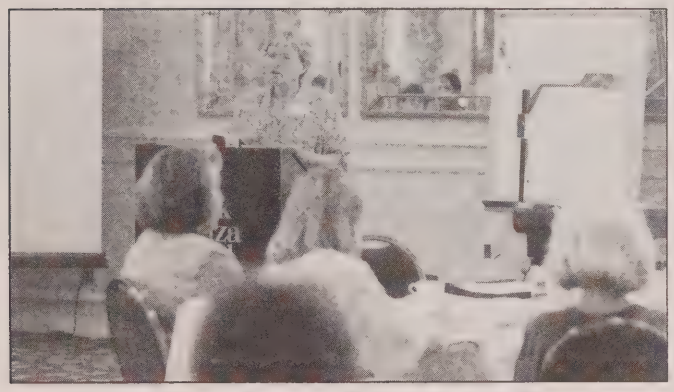
Meetings and Presentations

Educational Workshop

An education subcommittee was formed to help the Task Force address the terms of reference relating to educational issues. As part of its mandate, this subcommittee planned and carried out a workshop on March 27th. During this session, Dr. Rebeka Moscarello presented information on the psychiatric trauma and sequelae of sexual abuse, followed by Dr. Harvey Armstrong, who presented on the accommodation syndrome which appears in child sexual abuse. Dr. Armstrong indicated that all of the issues in child sexual abuse are equivalent to experiences of sexual abuse by someone in a position of power and trust. Dr. Carol Nadelson, the former president of the American Psychiatric Association, reported on key dilemmas and approaches to solutions in the area of sexual abuse by physicians and reported on progress in the United States on these issues.

Following these presentations, the workshop participants broke into small groups led by members of the education subcommittee to consider specific scenarios involving sexual abuse. The groups were asked to consider each of the scenarios from several perspectives:

1. How would you perceive this as a patient?
2. How would you perceive this as the physician involved?
3. What additional issues do you see for disabled, aboriginal and immigrant women?
4. What issues does this scenario raise for the profession?
5. What issues does it raise for the College of Physicians?



Dr. Joan Bain, speaking at the Educational Round Table

The findings of each workshop group were presented and discussed by all participants, and provided to the Task Force.

Meetings with College Staff

To gain insight into the thinking of those at the College directly associated with the complaints and discipline process, the Advisory Council heard a presentation by Dr. John Carlisle, Deputy Registrar of the College, on the present system for pursuing issues of misconduct. This was followed by a discussion with Dr. Jim Curtis, a College Council member and member of the Advisory Council, who outlined the legal limitations on members of the Discipline Committee at a hearing. Dr. Ross Dobson of the College Council also presented information to the Advisory Council on the burden a discipline hearing places on the doctor involved, and the patient factors which can be responsible for complaints. Dr. Nadelson, who joined this discussion, felt there was a disadvantage in the Ontario system of having nothing between the Complaints Committee review and a discipline hearing and advocated changes in this area.

Many of the Advisory Council members regretted that they had been unable to reflect directly to the presenters from the College how the process could re-victimize victims of abuse.

This discussion and discussion of the small group sessions at the workshop highlighted the distance between the varying starting perspectives of Advisory Council members, College Council, College staff and other participants. It was felt that ongoing education and discussion among this and other similar groupings was essential to share and improve the awareness and sensitivity required in addressing sexual abuse of patients.

Discussions of Education Issues:

At a discussion and review session on April 17th, the Advisory Council considered the barriers which hamper physician understanding and recognition of the reality of sexual abuse. Factors such as age, experience, medical education and the power of the physician in the doctor-patient relationship were discussed and debated in the context of the types of changes needed in medical education to overcome these barriers.

In reviewing medical education, a number of proposals were put forward to ensure that education is effective and reaches those most in need. Among these suggestions were: making education on sexual abuse mandatory for physicians and tying re-licensure to medical education in this area; requiring that physicians be informed of and acknowledge ethical statements by the College of Physicians and Surgeons; and specific education for College Council members.



Participants in the Legal Round Table

A number of other issues coming out of the Task Force hearings were raised during this meeting. The Advisory Council felt that hospital administrations must be more accountable in their handling of complaints of sexual abuse, as right now there is too strong a focus on the hospital's vulnerability when accusations about one of their doctors are put forward, and not enough concern with the vulnerability of patients.

The concept of mandatory reporting was also discussed and the suggestion put forward that some sort of sanctions could be put in place for those who fail to report sexual abuse of patients.

In looking specifically at the College of Physicians and Surgeons' role, the Advisory Council discussed the reality that the public does not believe the College's current system is a "level playing field" where their rights are equal to the doctors being complained about. The view was put forward that sexual abuse should be treated as incompetence in disciplining doctors, because no physician who abuses a patient can be competent to practice medicine.

The Advisory Council also highlighted the need for leadership by the College in this area, as physicians do pay attention to statements of principle coming from their self-governing body.

Review of Task Force Recommendations

In early May, the Advisory Council met to review a first draft of the Preliminary Report of the Task Force.

Following the presentation of the Preliminary Report to the College Council meeting on May 27th, 1991, the Advisory Council subcommittee on education worked with the Task Force to hold two Legal Round Tables and an Education Round Table. The legal forums brought together representatives of the legal and judicial communities to discuss their response to the recommendations requiring change inside and outside the College. Participants included prosecutors, defence lawyers, victim advocates and the judiciary.

The Education Round Table included representatives from the individual Ontario faculties of medicine, the Ontario Psychiatric Association, the committee on Education of Future Physicians of Ontario (EFPO), the Council of Faculties of Medicine of Ontario, the Ontario Medical Association, the College of Family Physicians of Canada, the Federation of Medical Licensing Authorities, the Ministry of Health, the Ontario Women's Directorate, the College, the Task Force and the Advisory Council. Following a presentation on the impact of sexual abuse on patients and an overview of medical education at the undergraduate, residency, and practising physician levels, the group discussed the recommendations which related to education of physicians.

At further Advisory Council meetings on June 19th and July 18th, the Council worked with the Task Force to consider responses from individuals and organizations to the Task Force Preliminary Report.

A major concern expressed at the July meeting was the original deadline for the Final Report of the Task Force to the College Council. The Advisory Council felt that to do justice to the original report and to the process of consultation, more time was required.

At our final meeting on August 14, 1991, we reviewed a draft of the revised Executive Summary and report. Throughout the time the Advisory Council has been meeting, it has shared its ideas, concerns and beliefs with the Task Force, and many of its ideas were reflected in the recommenda-

tions. The Advisory Council received the recommendations and the many responses to the Preliminary Report and reviewed them with the Task Force.

Conclusions



The Advisory Council met with the members of the Task Force regularly to exchange views

The Task Force on Sexual Abuse of Patients had a short time to do an enormous job. In spite of this, everyone realized at the outset that the work of the Task Force would have a great impact on the lives of people from many groups in our society. Finding a way to bring the perspectives of all those with a stake in this issue to the table was critical. Public hearings provided one avenue; the Advisory Council, with its diverse membership and broad range of expertise provided another.

The use of the Advisory Council to help gather information, to discuss and debate critical issues around sexual abuse of patients, to consider new ideas coming from the Task Force from a variety of perspectives and to offer support to the Task Force wherever possible has helped the Task Force to do a thorough, thoughtful analysis of the issues in the short time available to it.

The members of the Advisory Council are grateful for the opportunity to have been involved in this important endeavour.

Joan Bain, M.D., C.C.F.P., Chairperson, Advisory Council to the Task Force on Sexual Abuse of Patients

Appendix E

MINNESOTA CRIMINAL AND CIVIL LEGISLATION

Source:

Schoener, G.R., et al, Psychotherapists' Sexual Involvement With Clients: Intervention and Prevention, Walk-In Counselling Center, Minneapolis, Minnesota, pp. 670-675 and 710-713.

609.341 DEFINITIONS.

Subdivision 1. For the purposes of sections 609.341 to 609.351, the terms in this section have the meanings given them.

Subd. 2. "Actor" means a person accused of criminal sexual conduct.

Subd. 3. "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily harm or commission or threat of any other crime by the actor against the complainant or another, which causes the complainant to reasonably believe that the actor has the present ability to execute the threat, and also causes the complainant to submit.

Subd. 4. "Consent" means a voluntary uncoerced manifestation of a present agreement to perform a particular sexual act.

Subd. 5. "Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Subd. 6. "Mentally impaired" means that a person, as a result of inadequately developed or impaired intelligence or a substantial psychiatric disorder of thought or mood, lacks the judgment to give a reasoned consent to sexual contact or to sexual penetration.

Subd. 7. "Mentally incapacitated" means that a person is rendered temporarily incapable of appraising or controlling his conduct due to the influence of alcohol, a narcotic, anesthetic, or any other substance administered to that person without his agreement, or due to any other act committed upon that person without his agreement.

Subd. 8. "Personal injury" means bodily harm as defined in section 609.02, subdivision 7, or severe mental anguish or pregnancy.

Subd. 9. "Physically helpless" means that a person is (a) asleep or not conscious, (b) unable to withhold consent or to withdraw because of a physical condition, or (c) unable to communicate nonconsent and the condition is known or reasonably should have been known to the actor.

Subd. 10. "Position of authority" includes but is not limited to any person who is a parent or acting in the place of a parent and charged with any of a parent's rights, duties or responsibilities to a child, or a person who is charged with any duty or responsibility for the health, welfare, or supervision of a child, either independently or through another, no matter how brief, at the time of the act.

Subd. 11. "Sexual contact" includes any of the following acts committed without the complainant's consent, for the purpose of satisfying the actor's sexual or aggressive impulses, except in those cases where consent is not a defense:

(i) the intentional touching by the actor of the complainant's intimate parts, or

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by coercion or the use of a position of authority, or by inducement if the complainant is under 13 years of age or mentally impaired, or

(iii) the touching by another of the complainant's intimate parts effected by coercion or the use of a position of authority, or

(iv) in any of the cases above, of the clothing covering the immediate area of the intimate parts.

Subd. 12. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion however slight into the genital or anal openings of the complainant's body of any part of the actor's body or any object used by the actor for this purpose, where the act is committed without the complainant's consent, except in those cases where consent is not a defense. Emission of semen is not necessary.

Subd. 13. "Complainant" means a person alleged to have been subjected to criminal sexual conduct, but need not be the person who signs the complaint.

Subd. 14. "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another.

Subd. 15. **Significant relationship.** "Significant relationship" means a situation in which the actor is:

(1) the complainant's parent, stepparent, or guardian;

(2) any of the following persons related to the complainant by blood, marriage, or adoption: brother, sister, stepbrother, stepsister, first cousin, aunt, uncle, nephew, niece, grandparent, great-grandparent, great-uncle, great-aunt; or

(3) an adult who jointly resides intermittently or regularly in the same dwelling as the complainant and who is not the complainant's spouse.

Subd. 16. "Patient" means a person who seeks or obtains psychotherapeutic services.

Subd. 17. "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 18. "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 19. "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.

Subd. 20. "Therapeutic deception" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.

609.342 CRIMINAL SEXUAL CONDUCT IN THE FIRST DEGREE

Subdivision 1. **Crime defined.** A person is guilty of criminal sexual conduct in the first degree if he engages in sexual penetration with another person and if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant as to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(e) the actor causes personal injury to the complainant, and either of the following circumstances exist:

(i) the actor uses force or coercion to accomplish sexual penetration; or

(ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(f) the actor is aided or abetted by one or more accomplices within the meaning of section 609.05, and either of the following circumstances exists:

(i) an accomplice uses force or coercion to cause the complainant to submit; or

(ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual penetration, and:

(i) the actor or an accomplice used force or coercion to accomplish the penetration;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than 20 years or to a payment of a fine of not more than $35,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (g), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of a sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: *1985 c 24 s 5; 1985 c 286 s 15*

609.343 CRIMINAL SEXUAL CONDUCT IN THE SECOND DEGREE.

Subdivision 1. **Crime defined.** A person is guilty of criminal sexual conduct in the second degree if he engages in sexual contact with another person and if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the dangerous weapon to cause the complainant to submit;

(e) the actor causes personal injury to the complainant, and either of the following circumstances exist:

(i) the actor uses force or coercion to accomplish the sexual contact; or

(ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(f) the actor is aided or abetted by one or more accomplices within the meaning of section 609.05, and either of the following circumstances exists:

(i) an accomplice uses force or coercion to cause the complainant to submit; or

(ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual contact, and:

(i) the actor or an accomplice used force or coercion to accomplish the contact;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than 15 years or to a payment of a fine of not more than $30,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (g), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: *1985 c 24 s 6; 1985 c 286 s 16*

609.344 CRIMINAL SEXUAL CONDUCT IN THE THIRD DEGREE.

Subdivision 1. **Crime defined.** A person is guilty of criminal sexual conduct in the third degree if he engages in sexual penetration with another person and any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant shall be a defense;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 24 months older than the complainant. In any such case it shall be an affirmative defense, which must be proved by a preponderance of the evidence, that the actor believes the complainant to be 16 years of age or older. If the actor in such a case is nor more than 48 months but more than 24 months older than the complainant, he may be sentenced to imprisonment for not more than five years. Consent by the complainant is not a defense;

(c) the actor uses force or coercion to accomplish the penetration;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual penetration, and:

.(i) the actor or an accomplice used force or coercion to accomplish the penetration;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered person injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual penetration occurred during the psychotherapy session. Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a patient or former patient of the psychotherapist and the patient or former patient is emotionally dependent upon the psychotherapist; or

(j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual penetration occurred by means of therapeutic deception. Consent by the complainant is not a defense.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than ten years or to a payment of a fine of not more than $20,000, or both.

609.344 CRIMINAL CODE OF 1963

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (f), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: *1985 c 24 s 7; 1985 c 286 s 17; 1985 c 297 s 6*

609.345 CRIMINAL SEXUAL CONDUCT IN THE FOURTH DEGREE.

Subdivision 1. **Crime defined.** A person is guilty of criminal sexual conduct in the fourth degree if he engages in sexual contact with another person and if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age or consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant or in a position of authority over the complainant and uses this authority to cause the complainant to submit. In any such case, it shall be an affirmative defense which must be proved by a preponderance of the evidence that the actor believes the complainant to be 16 years of age or older;

(c) the actor uses force or coercion to accomplish the sexual contact;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual contact, and:

(i) the actor or an accomplice used force or coercion to accomplish the contact;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual contact occurred during the psychotherapy session. Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a patient or former patient of the psychotherapist and the patient or former patient is emotionally dependent upon the psychotherapist; or

(j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual contact occurred by means of therapeutic deception. Consent by the complainant is not a defense.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than five years or to a payment of a fine of not more than $10,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (f), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: *1985 c 24 s 8; 1985 c 286 s 18; 1985 c 297 s 7*

609.346 SUBSEQUENT OFFENSES.

Subdivision 1. **Definition; conviction of offense.** For purposes of this section, the term "offense" means a completed offense or an attempt to commit an offense.

Subd. 2. **Subsequent offense; penalty.** If a person is convicted of a second or subsequent offense under sections 609.342 to 609.345 or sections 609.364 to 609.3644 within 15 years of the prior conviction, the court shall commit the defendant to the commissioner of corrections for imprisonment for a term of not less than three years, nor more than the maximum sentence provided by law for the offense for which convicted, notwithstanding the provisions of sections 242.19, 243.05, 609.11, 609.12 and 609.135.

Subd. 3. **Prior convictions under similar statutes.** For the purposes of this section, an offense is considered a second or subsequent offense if, prior to conviction of the second or subsequent offense, the actor has been at any time convicted under sections 609.342 to 609.345 or sections 609.364 to 609.3644 or under any similar statute of the United States, or this or any other state.

History: *1975 c 374 s 7; 1978 c 723 art 1 s 16; 1981 c 273 s 4; 1984 c 588 s 9; 1984 c 655 art 1 s 77*

609.347 EVIDENCE.

[For text of subds 1 to 5, see M.S.1984]

Subd. 6. (a) In a prosecution under sections 609.342 to 609.346 involving a psychotherapist and patient, evidence of the patient's personal or medical history is not admissible except when:

(1) the defendant requests a hearing prior to trial and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial value.

(b) The court shall allow the admission only of specific information or examples of conduct of the complainant that are determined by the court to be relevant. The court's order shall detail the information or conduct that is admissible and no other evidence of the history may be introduced.

(c) Violation of the terms of the order is grounds for mistrial but does not prevent the retrial of the defendant.

History: *1985 c 297 s 8*

609.3471 RECORDS PERTAINING TO VICTIM IDENTITY CONFIDENTIAL.

Notwithstanding any provision of law to the contrary, no data contained in records or reports relating to complaints or indictments issued pursuant to sections 609.342, clause (a) or (b); 609.343, clause (a) or (b); 609.344, clause (a) or (b); 609.345, clause (a) or (b); or 609.3641 to 609.3644, which specifically identifies the victim shall be accessible to the public, except by order of the court. Nothing in this section authorizes denial of access to any other data contained in the records or reports, including the identity of the defendant.

History: *1985 c 119 s 1*

S.F. No. 1619

AN ACT

CHAPTER No. 372

relating to civil and criminal actions; providing acause of action for sexual exploitation; providing new procedures for enforcing restitution orders; amending Minnesota Statutes 1984, section 609.135, by adding a subdivision; proposing coding for new law as Minnesota Statutes, chapter 148A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [148A.01] [DEFINITIONS.]

Subdivision 1. [GENERAL.] The definitions in this section apply to sections 1 to 6.

Subd. 2. [EMOTIONALLY DEPENDENT.] "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.

Subd. 3. [FORMER PATIENT.] "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.

Subd. 4. [PATIENT.] "Patient" means a person who seeks or obtains psychotherapy.

Subd. 5. [PSYCHOTHERAPIST.] "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 6. [PSYCHOTHERAPY.] "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 7. [SEXUAL CONTACT.] "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or

anal openings of the psychotherapist's body by any pat of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

Subd. 9. [THERAPEUTIC DECEPTION.] "Therapeutic deception" means a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment.

Sec. 2. [148A.02] [CAUSE OF ACTION FOR SEXUAL EXPLOITATION.]

A cause of action against a psychotherapist for sexual exploitation exists for a patient or former patient for injury caused by sexual contact with the psychotherapist, if the sexual contact occurred:

(1) during the period the patient was receiving psychotherapy from the psychotherapist; or

(2) after the period the patient received psychotherapy from the psychotherapist if (a) the former patient was emotionally dependent on the psychotherapist; or (b) the sexual contact occurred by means of therapeutic deception.

The patient or former patient may recover damages from a psychotherapist who is found liable for sexual exploitation. It is not a defense to the action that sexual contact with a patient occurred outside a therapy or treatment session or that it occurred off the premises regularly used by the psychotherapist for therapy or treatment sessions.

Sec. 3. [148A.03] [LIABILITY OF EMPLOYER.]

(a) An employer of a psychotherapist may be liable under section 2 if:

(1) the employer fails or refuses to take reasonable action when the employer knows or has reason to know that the psychotherapist engaged in sexual contact with the plaintiff or any other patient or former patient of the psychotherapist; or

(2) the employer fails or refuses to make inquiries of an employer or former employer, whose name and address have been disclosed to the employer and who employed the psychotherapist as a psychotherapist within the last five years,

concerning the occurrence of sexual contacts by the psychotherapist with patients or former patients of the psychotherapist.

(b) An employer or former employer of a psychotherapist may be liable under section 2 if the employer or former employer:

(1) knows of the occurrence of sexual contact by the psychotherapist with patients or former patients of the psychotherapist;

(2) receives a specific written request by another employer or prospective employer of the psychotherapist, engaged in the business of psychotherapy, concerning the existence or nature of the sexual contact; and

(3) fails or refuses to disclose the occurrence of the sexual contacts.

(c) An employer or former employer may be liable under section 2 only to the extent that the failure or refusal to take any action required by paragraph (a) or (b) is a proximate and actual cause of any damages sustained.

(d) No cause of action arises, nor may a licensing board in this state take disciplinary action, against a psychotherapist's employer or former employer who in good faith complies with section 3.

Sec. 4. [148A.04] [SCOPE OF DISCOVERY.]

In an action for sexual exploitation, evidence of the plaintiff's sexual history is not subject to discovery except when the plaintiff claims damage to sexual functioning; or

(1) the defendant requests a hearing prior to conducting discovery and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial effect.

The court shall allow the discovery only of specific information or examples of the plaintiff's conduct that are determined by the court to be relevant. The court's order shall detail the information or conduct that is subject to discovery.

Sec. 5. Minnesota Statutes 1984, section 609.135, is amended by adding a subdivision to read:

Subd. 1a. [FAILURE TO PAY RESTITUTION.] If the court orders payment of restitution as a condition of probation and if the defendant fails to pay the restitution ordered prior to 60 days before the term of probation expires, the defendant's probation officer shall ask the court to hold a hearing to determine whether or not the conditions of probation should be changed or probation should be revoked. The court shall schedule and hold this hearing and take appropriate action before the defendant's term of probation expires.

Sec. 6. [148A.05] [ADMISSION OF EVIDENCE.]

In an action for sexual exploitation, evidence of the plaintiff's sexual history is not admissible except when:

(1) the defendant requests a hearing prior to trial and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial effect.

The court shall allow the admission only of specific information or examples of the plaintiff's conduct that are determined by the court to be relevant. The court's order shall detail the information or conduct that is admissible and no other such evidence may be introduced.

Violation of the terms of the order may be grounds for a new trial.

Sec. 7. [148A.06] [LIMITATION PERIOD.]

An action for sexual exploitation shall be commenced within five years after the cause of action arises.

Sec. 8. [EFFECTIVE DATE; APPLICATION.]

Sections 1 to 7 are effective August 1, 1986, and sections 1 to 7 apply to causes of action arising on or after that date.

Passed the House of Representatives March 14, 1986; passed the Senate March 15, 1986; Signed by Governor Rudy Perpich March 19, 1986; Filed by Secretary of State March 19, 1986.

Appendix F

PSYCHOTHERAPIST - PATIENT SEXUAL CONTACT - CRIMINAL OFFENSES IN SEVEN AMERICAN STATES

Copr. 1990, L. Jorgenson & R. Randles

PSYCHOTHERAPIST - PATIENT SEXUAL CONTACT
CRIMINAL OFFENSES IN SEVEN AMERICAN STATES

	MINNESOTA	WISCONSIN	NORTH DAKOTA	COLORADO	CALIFORNIA	MAINE	FLORIDA
CLASS OF PERSON COVERED	All who perform psychotherapy whether licensed or not	Same as Minnesota	Nearly identical to Minnesota	Nearly identical to Minnesota	Specific list of therapists or holds oneself out as one	Psychiatrist; psychologist social worker	Nearly identical to Minnesota
SEXUAL CONTACT	Intercourse; oral sex; sodomy; intended touching of intimate parts or clothing covering such part	Nearly identical to Minnesota	Nearly identical to Minnesota	Nearly identical to Minnesota	Nearly identical to Minnesota	Intercourse; oral sex; sodomy	Oral, anal, vaginal penetration
WHEN COVERED	1) During therapy session; 2) out of session if emotionally dependent on therapist or therapeutic deception	During any ongoing prof. relationship; in or out of therapy session	Only during therapy session	Same as Wisconsin (In or out of session)	Same as Wisconsin (In our out of session)	Same as Wisconsin (In or out of session)	Same as Wisconsin (In or out of session)
FORMER PATIENTS	Yes, forever; if emotionally dependent on therapist or therapeutic deception	No	No	No	Yes, when terminates to engage in sex; UNLESS refer to therapist recommended by third party therapist	No	Yes, when terminates primarily to engage in sexual contact
CONSENT	Not a defense	Not a defense	Not a defense	Not a defense	Not a defense	Victim to prove intimate relationship, trust, dependence, substantial potential for vulnerability and abuse	Not a defense
PENALTY	Felony; penetration; up to 10 years or $20,000; contact; up to 5 years or $10,000	Felony; class D; up to 5 years or $10,000 fine or both	Felony; class C; up to 5 years or $1,000 fine or both	Felony; class 4; 2-8 years; $1,000 - $100,000 fine or both	1st offense misdemeanour; other offenses are wobblers max. penalty 1 year and/or fine	Felony; class C; 3-5 years	Felony; third degree; second offense, second degree felony

Appendix G

LICENSURE-RELATED REPORTING REQUIREMENTS IN MINNESOTA

Source:

Schoener, G.R. et al, Psychotherapists' Sexual Involvement With Clients: Intervention and Prevention, Walk-In Counselling Center, Minneapolis, Minnesota, pp. 698-700.

Health care professionals in Minnesota, by virtue of being licensed, are mandated reporters of sexual misconduct by other health care practitioners. These mandates are contained in various licensing statutes, or in one case, in the Rules of Conduct established by a board of licensure.

PSYCHOLOGY: The Rules of Conduct, adopted by the Minnesota Board of Psychology on August 7, 1982 (7 MCAR § 10.008 Rules of Conduct.) contain the following reporting mandate:

10. A psychologist shall file a complaint with the board when the psychologist has reason to believe that another psychologist is or has been engaged in conduct which violates C.11., failure to report suspected abuse of children or vulnerable adults, or E.8., sexual contact with a client. This requirement to file a complaint does not apply when the belief is based on information obtained in the course of a professional relationship with a client who is the other psychologist. Nothing in this rule relieves a psychologist from the duty to file a report as required by Minn. Stat. § 626.556 or 626.557, reporting abuse of children and vulnerable adults.

[Minn. Stat. § 626.557 is contained in Appendix J. Sections C.11. and E.8. referred to above are presented below.]

C.11. In the course of professional practice, a psychologist shall not violate any law concerning the reporting of abuse of children and vulnerable adults.

[Section 8 below was changed in rules adopted July 14, 1989. New language is underlined]

E.8. A psychologist shall not engage in sexual intercourse or other physical intimacies with a client, nor in any verbal or physical behavior which is sexually seductive or sexually demeaning to the client. Physical intimacies include handling of the breasts, genital areas, buttocks or thighs of either sex by either the psychologist or the client. A psychologist must not engage in sexual intercourse or other physical intimacies with a former client for a period of two years following the date of the last professional contact with the client, whether or not the psychologist has formally terminated the professional relationship.

MEDICINE (INCLUDING PSYCHIATRY): The Medical Practice Act, as amended in 1985 (Minn. Stat. 147), contains the following reporting mandate:

147.111 [REPORTING OBLIGATIONS.]

Subd. 1. [PERMISSION TO REPORT.] A person who has knowledge of any conduct constituting grounds for discipline under § 147.01 to 147.33 may report the violation to the board.

Subd. 2. [INSTITUTIONS.] Any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condiction a physician's privilege to practice or treat patients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action. The institution or organization shall also report the resignation of any physicians prior to the conclusion of any disciplinary proceeding, or prior to the commencement of formal charges but after the physician had knowledge that formal charges were contemplated or in

preparation. No report shall be required of a physician voluntarily limiting his or her practice at a hospital provided that the physician notifies all hospitals at which he or she has privileges of the voluntary limitation and the reasons for it.

Subd. 3. [MEDICAL SOCIETIES.] A state or local medical society shall report to the board any termination, revocation, or suspension of membership or any other disciplinary action taken against a physician. If the society has received a complaint which might be grounds for discipline under § 147.01 to 147.33 against a member physician on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the board of medical examiners.

Subd. 4. [LICENSED PROFESSIONALS.] A licensed health professional shall report to the board personal knowledge of any conduct which he or she reasonably believes constitutes grounds for disciplinary action under § 147.01 to 147.33 by any physician, including any conduct indicating that the physician may be medically incompetent, or may be medically or physically unable to engage safely in the practice of medicine. No report shall be required if the information was obtained in the course of a physician-patient relationship if the patient is another physician and the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment.

[NOTE: Subd. 5 provides requirements for quarterly reports from all malpractice insurance carriers, and Subd. 6 reports from the District Court.]

Subd. 7. [SELF-REPORTING.] A physician shall report to the board any action concerning himself or herself which would require that a report be filed with the board by any person, health care facility, business, or organization pursuant to subdivisions 2 to 6.

****

147.121. [IMMUNITY.]

Subd. 1 [REPORTING.] Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the board pursuant to § 147.111 or for otherwise reporting to the board violations or alleged violations of § 147.021. All such reports are confidential and absolutely privileged communications.

****

147.131. [PHYSICIAN COOPERATION.]

A physician who is the subject of an investigation by or on behalf of the board shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of patient medical records, as reasonably requested by the board, to assist the board in its investigation. The board shall pay for copies requested. If the board does not have written consent from a client permitting access to his or her records, the physician shall delete any data in the record which identifies the patient before providing it to the board....

****

The grounds for disciplinary action are listed in 147.021, subdivision 1. The grounds are very broad Two that are of relevance to physician-patient sex are:

(t) Engaging in conduct with a patient which is sexual or may be reasonably interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by 147.111 or to cooperate with an investigation by the board as required by 147.131.

SOCIAL WORK, MARRIAGE AND FAMILY THERAPY, AND UNLICENSED MENTAL HEALTH SERVICE PROVIDERS: These three groups were regulated beginning in 1987 through the creation of a new law, Minnesota Statutes 148B. This law has requirements for institutions, professional societies, and insurance carriers, as well as self-reporting which are virtually identical to that required by the Medical Practice Act. However, one section differs slightly:

148B.07 [REPORTING OBLIGATIONS.]

Subd. 4 [REGULATED INDIVIDUALS AND LICENSED PROFESSIONALS.] A regulated individual or a licensed health professional shall report to the appropriate board personal knowledge of any conduct that the regulated individual or licensed health professional reasonably believes constitutes grounds for disciplinary or adverse action under this chapter by any regulated individual, including conduct indicating that the individual may be medically incompetent, or may be medically or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is another regulated individual, and the treating individual successfully counsels the other individual to limit or withdraw from practice to the extent required by the impairment, the board may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Appendix H

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ACKNOWLEDGEMENTS

When the College invited me to chair this independent Task Force, none of us had a clear sense of how the Task Force would operate, from where it would operate, how much time and money it would cost, or how much support from College staff and others would be required. I believe it is fair to say that the presence of the Task Force in the midst of the College's predictable daily routines has been disruptive. Since we mutually established a very demanding timeline (some described it as impossible), crisis management has been a daily occurrence, especially for Briar, our miracle-working Coordinator, who experienced the gestation of her wonder child, Cooper, at the same time as she exceeded all of our expectations in the gestation of the Reports. When Briar left us to have her baby, Bonnie added coordination duties to her already daunting job of word processing and editing hundreds of pages.

On behalf of Bonnie, Briar, Harvey, Pat, Rachel and Roz, I want to thank all those at the College who extended themselves to help us do the virtually impossible and deliver these Reports. We feel that the leadership of the College has done its best to respond to the numerous unexpected needs and costs generated by the Task Force. We are especially grateful to the following staff members of the College:

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Before the Preliminary Report, the Advisory Council conducted an educational seminar for College Council and staff and following the Preliminary Report, Joan Bain and Roz Roach co-chaired the Education Round Table which brought together most of the key players necessary to generate an effective game plan for short term and long term change. We thank all the participants whose names are listed at the end of this section.

As the only lawyer on the Task Force, I had a moment of pure panic when I realized that only two of the Terms of Reference for the Task Force did not have a legal component. However, my colleagues on the Task Force brought their strong analytical skills to the challenge and consultations with Rosie Abella, Mary Eberts, Julian Porter, Zulie Sachedina and Beth Symes generated three Legal Round Tables, which we held before and after the Preliminary Report. The participants of the Legal Round Tables, plus those experts who provided additional commentary are listed at the end of this section. I am personally indebted to Mary Eberts and Beth Symes for the extraordinary professional support they extended to me.

In an interesting way, the backlash from doctors enhanced this Final Report because the anger and denial in hundreds of doctors' responses to the Preliminary Report prompted the Task Force to closely examine the legal foundation of our Preliminary Recommendations. We are indebted to the distinguished law firm of Osler, Hoskin & Harcourt (OH & H) which accepted the Task Force as a "pro bono" client and provided a team of students which examined, from a legal perspective, many of the Preliminary Recommendations. John Claydon, the Director of Education at Osler, Hoskin & Harcourt assembled the following exceptional team: law students Rosanne Giulietti, Mitch Goldberg, Sarah Kay, Heather McArthur, Craig Penney and David Roney, with special recognition to the leadership and coordination of Karen Fellowes and Peter Chapin, whose dedication ensured the high quality of the legal research, assisted by secretaries Kathryn Chubb, Carin Bruckner and Lee Ann Hancin. Lawyers David Stratas and David Morritt also provided input.

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It was a fine moment when the Task Force team realized that we indeed were going to be able to present a consensus Preliminary Report. Pressures on members of the Task Force in reaction to the Preliminary Report tested us to reach consensus in this Final Report. Once again, each of us has contributed, and we make our final recommendations in unison. We want to thank the three highly experienced editors who volunteered their skills for the Preliminary Report: Sally Armstrong, the Editor-in-Chief of Homemakers Magazine; Val Monroe, Consulting Editor to Mirabella; and the College's own Linda Franklin. To help us complete the Final Report, Val and Linda donated much more of their expertise. As well, Linda Rosenbaum and Deborah Sutton responded to urgent calls for their editorial and writing skills.

Lastly, the beginning - the cover and the Chapter 1 illustration which are the same for both Reports. The artist wishes to remain anonymous, but she will read this and we want her to know that we did not change the cover for the Final Report because of the positive response to the Preliminary Report. We also want to acknowledge her courage and her generosity in sharing so poignantly the reality of sexual abuse.

Marilou McPhedran
November 1, 1991

Legal Round Table April 14, 1991

Our thanks to participants: Linda Bohnen, Colin Campbell, Robert Cosman, Mary Eberts, Rebecca Gotlieb, Joyce Harris, John I. Laskin, Eleanor Meslin, Anne Molloy, Julian Porter, Margaret Ross, Zulie Sachedina and Beth Symes.

Legal Round Table June 18, 1991

Our thanks to participants: Linda Bohnen, Janne Burton, John Carlisle, Mary Eberts, Marlys Edwardh, Rebecca Gotlieb, Joyce Harris, Fran Kitely, Julian Porter, Zulie Sachedina, Richard Schecter, Rebecca Shamai, Beth Symes and Tracey Tremayne-Lloyd.

Legal Round Table June 19, 1991

Our thanks to participants: Cathy Belanger, Rhonda Bessner, Ted Bodeway, Susan Byles, Colin Campbell, Clare Dobson, Temi Firsten, David Giufrida, Bev Janes, Carolyn Kidd, John I. Laskin, Willson McTavish, Anne Molloy, Brenda Pearce, Julian Porter, Ethan Poskanzer, Nora Angeles Richardson, Margaret Ross, Zulie Sachedina, Laurie Stoltz and Neal Sutton.

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Education Round Table June 19, 1991

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